Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JUDITH LYNN\_HEITZ DECEMBER 16. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 212 F Delaware Director June 17. 1944 203-34-1475 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantary must be multified at ONCE. 1 □Yes 2 □NO Director Maryland Harford Bel Air 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 1012 Seamount Road 21015 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**O 1 ☐ Yes 2 ▼No Specify: 3 Widowed 4 Divorced White Completed Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Education 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Dorothy Elizabeth Starr John Robert Mearns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1012 Seamount Rd., Bel Air, MD 21015 <u> Michael W. Heitz / Husband</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 12-21-08 | West Chester, PA 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Uneral Service Lensee 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LETA STATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine HYPERTENSION After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FÉMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Matural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death cases and the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier EMMORTON ROAD SUITE 212 2101 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2227 MO Allmoon

State Registrar Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	Maryland / D	Department of He Certificate of De			711115	40502
			1. Decedent's Name (First, Middle, Last)		Certificate of Di		Reg. No. Date of Death		3. Time of Death
	Physicia /Medic		Frederick	Euc	gene Harbert		Month December	ay Year 14,2008	9:09 № м
	Examin		4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Lo			c. County of Death	
	Formand		Johns Hopkins Bayview Me 5. Social Security Number 6. Sex 7.	edical Ct: Age (In yrs. last bir	thday) If Under 1 Year	11timore (	B. Date of Birth (Month, Day, Year	N/A 9. Birth	place (State or Foreign
	Funeral Director		232-32-6995 15€M 2□F	80	Yrs. Months Days	Hours Min.	March 24	,1928 We	est Virginia
	ww.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits
	Maryli Ff sho	tor	Maryland Baltimore		Dund	lalk			1 □ Yes 2X No
	th the	Director	10e. Street and Number		10f. Zip Code			citizen of What Cou	
	s 23a	eral	7821 Saint Boniface Lane	ant Ever in IIS	21.2			nited Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Madical Examinar is not be notified at once.	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Force  1.□ Never Married  2.□ Was Decedent Armed Force  1.□ Was Decedent Armed Forc	es? □ No	13. Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes ঽৣঢ়ৢৢNo	Mexican, Puerto Ri	ican, etc.)	Black, White,	
2-0	72 hou natura lical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a.	. Decedent's Usual Occupati (Give kind of work done du	ion ring most of working	16b.	Kind of Business/Ir	idustry
21215-0036	vithin and and and and and and and and and an	Completed by	Elementary/Secondary (0-12) College (1-4	or 5+)	\langle \text{life. DO NOT use retired} \\ \text{Steel Work} \\ align*			Steel Ind	lustry
d 2	filed v I Hygid other i	Be Co	17. Father's Name (First, Middle, Last)		1	,	First, Middle, Maide	n Surname)	
/ian	uld be Menta arked atic ev	To B	Chester G. Harbert			Lona Gr			
Maryland	2 sho hand risma rauma		19a. Informant's Name/Relationship (Type. Print) Mrs. Esther M. Harbert (		o. Mailing Address <i>(Street an</i> 7821 Saint Bo				
<u>ရ</u> ်	1 and Healt tem 2		20a. Method of Disposition		f Disposition (Name of iry, crematory or other place)			Location - City or T	· <del>-</del>
ē	Pages nent of int; If i		1X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate	<i>lawn Cemetery</i>	12/18	/2008	Baltimore	e, Maryland
Baltimore,	permit. Departn Importa any inju once.		21. Signature of Jun ral Servic / ice see	- 30000	22 Name and Address Duda-Ruck	funeral E	Home of Di		
	40 <b>2 % 4</b>	-	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	used the death. Do	7922 Wise not enter the mode of dying,			ryland 21	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	h line.	int int	arche	and		Onset and Death
-)	/Medical	П	reculting in death)	r as a consequence	of):	)			
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	as a consequence	MUTTO of):	<u> </u>			-
/	uted d ansit	Examiner	Cause, Chite Underlying Cause, Chite Underlying Chite (Disease or injury that initiated events	aluti	est				
, Ö	ficate be executed physician and s the burial-transit	l Exa	resulting in death) Last Due to (or	r as a consequence	of):		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
8760,	physic physic the b	dical	d						
P.O. Box 6	sath certi attending for use a	Physician/Me	23b. Was decedent pregnant 1 Live bit	ome of pregnancy rth 2  Fetal death that time of death wn	h 3  Ectopic pregnancy 5 Other (specify)			23d. Date of deli	very Day Year
S, D.	s that t ned by a detac	by Ph	Part II. Other significant conditions contributing to dea	th but not resulting i	in the underlying cause giver	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords S	equire een sig ould b	ed b					1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
Division of Vital Record	ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	Completed					24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of 2 □ No
Ĭ;	sician certifi irector	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 In In	patient 2 ☐ ER/O	Other	26. Place of Death	(Check only one) ne 5 ☐ Residence	6 □Other (Spa	nih()
اه د	<b>ling Phy</b>  After this funeral d	ü	27. Manner of Death 28a. Date of	Injury 28b.	Time of Injury Work?		8d. Describe how in		
sior	tendin eath. or: Af the fur	catio	2 Accident investigation		M 1 □Y	es 2□No			
Σ	or At after d Direct in by	Certification: To	determined 200, Flace C	if Injury - At home, to g, etc. <i>(Specify)</i>	arm, street, factory, office		8f. Location (Street City or Town, Sta	and Number or Hu ite)	rai Houte Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier  Certifying Physician: To the ba	pest of my knowledg	ge, death occurred at the time and/or investigation, in my op	e, date and place, a inion, death occurre	and due to the cause and at the time, date a	e(s) and manner as	stated. to the cause(s)
	the Formula 24	Medical	one) and manne	er stated.	29c. License	number	29d. I	Date signed (Month	ı, Day, Year)
	¥¥¥ ا	/	Mary las	rall	V 128	3177	/	2/15/	08
	1.41	-	30. Name and address of person who completed cause	of death (Item 23a)	(Type, Print)				
	U		2	O Philade gistrar's Signature		Suite 108	Baltimore	≥, MD 21	.237
	Sta Regist		DFC 1 8 2008	was A	Come				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	, , ,	Certificate of L	Death	Reg.	No. 2008	40003
ı	Physici		Decedent's Name (First, Middle, Last)     SÄUL	Z	HAMMERMAN		2. Date of Death	Ŕ <sup>ay</sup> 15 2008	3. Time of Death 4:21 P M
	/Medio		4a. Facility Name (If not institution, give stre			Location of Death		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 111-18-7748	2□ F 82	irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 06/24/19	9. Birth Cou	nplace (State or Foreign untry) NY
	the Maryland 28a-f show	Director	Usual Residence of Decedent		wn or Location  BALTIMORE  10f. Zip Code		10g.	Citizen of What Cou	10d. Inside City Limits 1 □ Yes 2 💆 No
	3a or	al Dir	6708 BAYTHORNE ROA	AD.		209		USA	·
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modicul Evanine must be notified at once.	d by Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWIII If Yes, Give Year or Dates: NAVY	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spo an, Mexican, Puerto Specify:		14. Race - Amer Black, White Specify: WHI	, etc. TE
1215-0	within 72 ho ene. than "natu	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)		a. Decedent's Usual Occup (Give kind of work done of life, DO NOT use retired CANTOR	ation during most of worki d)	ng	RELIGION	ndustry
1d 2	e filed al Hygi other /ent, II	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid		
ylar	ould be Menta arked aric e	To E	SAMUEL	HAMMERMAI		REBECC		KASTAN	
Mar	nd 2 shallth and alth and 27 is m	100	19a. Informant's Name/Relationship (Type.  AILEEN HAMMERMAN /		b. Mailing Address (Street 6708 BAYTHOR				
Baltimore, Maryland 21215-0036	Pages 1 ar nent of Hea int: If item :	-	20a. Method of Disposition 1	20b. Place of cemeter	of Disposition (Name of ery, crematory or other plac EL MEMORIAL P			c. Location - City or T	
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee	7	22. Name and Addres			N & BROS. KESVILLE,	
	Physician ) /Medical Examiner		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a consequence	ge renal			,	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence					
O. Box	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		ey .		23d. Date of deli Month	ivery Day <b>Y</b> ear
rds, P.	The law requires that the ate has been signed by th page 2 should be detache	Š	Part II. Other significant conditions contrib	outing to death but not resulting	in the underlying cause giv			cco use contribute to	the cause of death?
Division of Vital Records,		Completed	Peripheral VAS	cular dise	AIE		24a. Was an autopsy performed 1 ∐Yes 2 ☑	prior to o	topsy findings available completion of cause of 2 □No
Vita	Physician: The this certificate ral director, pag	æ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Oth	or	h <i>(Check only one)</i> ome 5□ Residenc	ce 6 ☑Other (Spe	city 1+0306
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To			. Time of 28c. Injur		28d. Describe how		Gilly) ( O - Jo 1
Divis	tal or Atters s after des al Director	Certifica		28e. Place of Injury - At home, 1 building, etc. (Specify)	farm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in bits of the terms of t	Medical (	29a. Certifier 1	ian: To the best of my knowledger: On the basis of examination a and manner stated.	lge, death occurred at the ti and/or investigation, in my o	ime, date and place opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	Tot with Tot	Σ	29b. Signature and title of certifier	, they.		se number	290	l. Date signed (Monti	h, Day, Year)  15, 2008
	10		30. Name and address of person who com	oleted cause of de the Item 23a	a) (Type, Print) V. Charles.	St. Ra	Gr. 101	1 2,20,	k
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	South				

December 15, 2008

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			Cei	rtificate of	Death	ĺ	Reg. No.	UUV	40004
	Di		1. Decedent's Name (First, Middle	, ,					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Elinor E		ager				Month	15	2008	4.30am
	Examin		4a. Facility Name (If not institutio	n, give street and number	er)		4b. City, Town, o	r Location of Dea	th	4c. (	County of Death	
-e/			Howard County		Arr		Columb				oward	(0)
	Funeral Director		5. Social Security Number 216-22-1447	6. Sex 7. 1 □ M 2 ☑ F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		iv. Year)	Coun	lace (State or Foreign try) land
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation				11	0d. Inside City Limits
	sho	5	Tour out				odtion				1	1⊠Yes 2□No
	he M	Directo	MD Howar  10e. Street and Number	a.	Co.	lumbia	10f. Zip Code			10a Citiz	en of What Coun	
	a or			m 7								шут
	eath	era	6500 Freetown  11. Marital Status	12. Was Decede	nt Ever in U.S	3 13 1	21044	dispanic Origin? (	Specify Yes or No	U.S.	A . 4. Race - Americ	an Indian
	ter d	Funeral	1 Never Married 2 Mar	Armed Force	s?		Was Decedent of F f Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)	i	Black, White, e	etc.
3	ursal	by	3 XWidowed 4 ☐ Divorced	If Yes, Give			I∐Yes 2∭XNo	Specify:			<sup>Specify:</sup> Whit	e
Ō.	2 hou	ted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	oation	auleim m		d of Business/Ind	
21	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, I'm Modical Exain har huat be notified at	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. L	kind of work done OO NOT use retire	d)	nking			
7	ed wi ygier Ner th	ပ္ပ	11			Homem	aker				Home	
ב	be fill Ital H Id oth even	Be	17. Father's Name (First, Middle,						me (First, Middle	, Maiden S	Surname)	
<u>\frac{1}{2} </u>		ြို	Ernest Latlief					Susie				
_	2 8 8		19a. Informant's Name/Relations				ng Address (Street					Code)
a)	1 and 2 Health em 27		Larry Iager  20a. Method of Disposition	/nephew	20h Bi		Highway	<del></del>	Date MO		a 59725 cation - City or To	wn State
و	Pages nent of I int: If Ite		1X Burial 2 ☐ Cremation		te		sition (Name of natory or other pla	i			•	
	it. Partme		4 Donation 5 Other (S		St.		s Cemete				on, Mary	land
Ba	permit. Pages Department of Important: If II any injury or once.		21. Signature of Juneral Service	Lioens	M007	772 5	. Name and Addre Onaldson	Funeral	Home, P	.A.	207.	07 4300
			23a. Part 1. Enter the disease, or	r complications that caus			13 Talbot				and 2070	
			shock, or heart failure. List Immediate Cauce (Final	only one cause on each	iline.	,		ng, sasir as sarah	ao o roopiiato y a			Approximate Interval Between Onset and Death
- F	hysician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	reum	1119				_	Days
E	Examiner			Due to (or	as a consequ		2919					months
		ē	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	enca of:	,					2-10-1/-/3
	outed ansit	Examiner	Cause (Disease or injury that initiated events		Bu	elbar	upper	Motor 1	recen	atter		months
o	e exected an arrial-tr		resulting in death) Last	Due to (or	as a consequ	ence of):	7//					
68760,	death certificate be executed attending physician and dror use as the burial-transit	Medical		d								
9	erund ling pl	Med	IF FEMALE:									
Box	eath cer attendin for use	au/	23b. Was decedent pregnant in the past 12 menths?		h 2 Fetal	death 3	Ectopic pregnanc	у		2	3d. Date of delive Month	ery D <i>a</i> y Year
0	rne deg	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow	nt at time of de n	eath 5□	Other (specify) _				World	Day You.
٦.	w requires that the de been signed by the s should be detached	P <sub>P</sub>	Part II. Other significant conditi	ons contributing to death	n but not resu	lting in the ur	nderlying cause giv	en in Part I	23e. Did 1	obacco us	se contribute to th	ne cause of death?
g,	requires that been signed b hould be deta	þ	Tarrii Otilor olgililloziik ooriala	one contributing to doub	. Dat Hot look	ining in the di	idonying educe gri	on are are a	1 🗆			ably 4 🗆 Unknown
Ö	been	etec										,
Records,	the law cate has b page 2 sh	Completed							24a. Was auto		prior to col death?	psy findings available mpletion of cause of
_ +	ician: The lav certificate has ector, page 2 s		or was a second to see the						1 □Yes	2. No	1 □ Yes	2 <b>□</b> 1√0
Vital	rnysicians r this certific ral director,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	O T	FD/0- 4	ot 3 🗆 DOA Oth	OF:	eath (Check only o	/	Пои из и	
<u></u>	r this aral dii	٠ <u>۲</u>	27. Manner of Death	28a. Date of I		28b. Time of	N OLI DOA	4 Li Nuising	Home 5 ☐ Resi			y)
Division of	l or Attending Priystclan: after death. Director: After this certific I in by the funeral director, I	ţi	1 Natural 5 Pendir 2 Accident investi	ig '	Day, Year)	Injury		ki? ]Yes 2 ∭ No				
SIN	after deatl Director: I in by the	ijij	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Place of	Injury - At ho	me, farm, str	eet, factory, office	m e	28f. Location (	Street and	Number or Rura	l Route Number,
ā	s after start of all Direction	Certification:	4 🗆 Hornicide	building,	etc. (Specify	′/			City or To	wn, State)		
	o the hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	ledical (		ng Physician: To the be Examiner: On the basi and manner	s of examinat							
	Vithir To the	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
	_		. Scarl.	2	MO		D-	53636		Dec	15,20	108
	12		30. Name and address of person	who completed cause of	of death (Item	23a) (Type,	Print) Charte	1000	- Color		a NI	200410
	Sta Registr		31. Date filed (Month, Day, Year)	32 Regi	strar's Signat	ure	will s	100	_ au.	The state of	4 77	
			DEC 18	LUUU FARME	154 15	-	- Albaria					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certific	ate of De	ath	F	leg. No.	U U &	40.	000
	Physicia	an.	1. Decedent's Name (First, Middle, Last, STANLEY FRANK J						Date of Dea     Month	Dav	Year	3. Time of	Death M
1	/Medic	al	4a. Facility Name (If not institution, give			4b. C	ity, Town, or Loc	ation of Death	December		nty of Death	5:50A	191
1	LAGIIII		Brighton Gardens				Baltimore				ltimore		
	Funeral Director		210-20-2000 /	x 7. Age M 2□ F 82	(In yrs. last bi	Yrs. Mont	der 1 Year If hs Days H	Hours Min.	8. Date of Birtl (Month, Day February	23, 1926	6 Mary	place (State of ntry) and	r Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						I0d. Inside Cit	y Limits
	e Mar Ba-fsh	ctor	Maryland Baltimore		Towsor							1 □ Yes	XX No
	with th	Dire	10e. Street and Number 608 Worcester Road			10f.	Zip Code 21286			10g. Citizen (		ntry?	
9	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examination ust by redflind at	/ Funeral Directo	11. Marital Status 1 □ Never Married   Married	12. Was Decedent E Armed Forces? 100 Yes 2 □ No If Yes, Give	ver in U.S.		cedent of Hispa specify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,		
215-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a		Isual Occupation	n			f Business/In		
215	hin 72 e. an "na Medic	Completed	(Specify only highest grad	le completed)  College (1-4or 5+		(Give kind of life. DO NO	work done durir T use retired)	ng most of work	ing				
21	filed wit Hygien Ither the	Con		4		Accour		Mother's Nam	e (First, Middle,		acturing	1	
anc	d d d	To Be	17. Father's Name (First, Middle, Last)	Frank	Jozwiak	ζ.	10.		Mackowial		iamo)		
Maryland 21	shoul and M is mar	-	19a. Informant's Name/Relationship (T)	,	M		,		al Route Numbe		wn, State, Zi	o Code)	
ອົ ອົ	and 2 Health Im 27 Iher tra		Steven R Jozwiak	Sc		B Worces of Disposition (			aryland 2		on - City or To	own State	
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1		cemete	Valley	or other place) <b>1em Garder</b>	ns   12/19	/08	Timoni	ium, Man	ryland	
Ball	permit. Pag Department Important: I any injury c		2 rature of Funer Cens	KonKer	rake	U	6500 York	k Road Ba	hell-Wiedd ltimore, M	Marylano		tome Inc.	
	Physician		23a. Part 1. Enter the disease, o comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused ne cause on each line	the death. Do	not enter the	mode of dying, s Mといて	such as cardiac	or respiratory ar	rest,		Approximate Interval Beth Onset and D	veen
	/Medical Examiner		resulting in death)	a. Due to (or as a	consequence							0.	
		e	Sequentially list conditions,	b	OCRSH UHRON	of)r							
0	scutèd nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С									
60,	icate be executêd physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):							
68760,	rtificate be executêd ng physician and s as the burial-transit	Medical		d									
Вох	ath ce attendi or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 ☐ Live birth 3	2 🗌 Fetal deat	h 3 Ector	ic pregnancy (specify)			23d.	Date of deliv		'ear
<u>Р</u>	at the de I by the a stached t	hys	9 ☐ Unknown	9 Unknown					00 - Did 4		andributa to	the serves of d	noth?
rds,	w requires that s been signed t should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the underlyi	ng cause given in	n Part I.	23e. Did to			the cause of d	Jnknown
Il Records,	The la ate has page 2	Completed				-			24a. Was autop perfor 1 □Yes	sy	tb. Were aut prior to co death? 1 □Yes	opsy findings a ompletion of ca 2  No	available ause of
Vita	sician certifi rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ACIEDIO		100		th (Check only one)		Oth (0	ΔIF	-
ō	iding Phys th. After this funeral dir	n:To	27. Manner of Death	1 ☐ Inpatie	y 28b.	utpatient 3 [ Time of Injury	28c. Injury at Work?		28d. Describe h			ny) / C	
Sior	Attendin death. ctor: Aff y the fur	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M	1 □ Yes	2 □ No					
Division of	tal or At s after d al Direct ed in by	Certification: To	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, f . <i>(Sp</i> ec <i>ify)</i>	arm, street, fa	ctory, office		28f. Location (S City or Tox		ımber or Hui	al Houte Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	yslclan: To the best of iner: On the basis of and manner sta	examination a	ge, death occu ind/or investig	rred at the time, ation, in my opini	date and place ion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s	)
	To the within To the compl	Me	29b. Signature and title of certifier	$\sim$			29c. License nu	umber		29d. Date sig	gned (Month	Day, Year)	
	^		Dendall	LKJa	elle		<u> </u>	564	3	10/1	2/9	4008	
	10		30. Name and address of person who c	ompleted cause of de		(Type, Print)	m. P	310d/	Baltz	m)	217	04	
	Site	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					, ,			

Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09417 State of Maryland / Department of Health and Mental Hygiene Jesse Margaret Johnson Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 15, 2008 0545 hrs Medical Examiner Jessie Margaret Johnson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2326 Belair Road, Garage #5 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Hours Months Days Director 212-48-0441 12-11-1949 M 2 X F 58 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location апу 10a, State 10b. County X Yes 2 28a-f show N/A MD Baltimore s 23a or 28a-f show e notified at once. Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 4145 Eierman Avenue 21206 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Callimore, MD 21215-0036

Dermit. Pages I and 2 should be filed within 72 hours after death with Pepartment of Health and Mental Hygiene.

Thorizant: If item 27 is marked other in a content transmitted other in a cont Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) marked other than "natural", or items cevent, the Medical Examiner must be Armed Forces? 1 Never Married 2 Married Yes 2 X No Specify: Black Yes 2 X No specify: 3 X Widowed s. Give Yea 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Disabled Disabled 12th grade N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reaver Baker Be Jesse James Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheila Carroll-Ogle 4145 Eierman Avenue Balto, MD 21206

re of Disposition (Name of cemetery. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 12-19-08 Balto, MD 4 Donation 5 Other Specify: March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical a Carbon monoxide Toxicity Immediate Cause (Final disease iaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. and Physician/Medical **AMENDED** attending physician or use as the burial UNPENDED 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 3b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown á Completed 24b. Were autopsy findings available 24a. Was an as been s 2 should 1 pnor to completion of cause of autopsy performed' death? has b Yes 2 V No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 DOA ER/Outpatient 3 Inpatient 2 After this 1 V Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Exposure to carbon monoxide fumes Certification: FOUND: 1 Yes 2 ✔ No 1 Natural 5 Pending 0500 hrs Dec 15, 2008 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc

Division of Vital Records, P.O. filled in by the f within 24 hours at To the Funeral D

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 1 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie December 15, 2008 O.C.M.E.

or Town, State) 2326 Belair Road, Garage #5, Baltimore, MD

30. Name and address of person who completed cause of death (item 23a)

Could not be

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 32: Registrar's Signature

(Specify) Storage Garage

31. Date filed (Month, Day, Year) State DEC 1 Registra

Suicide

Homicide

3

Wedical

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death edent's Name (First, Middle, Last) Day Year 3,2008 4c. County of Death Physician /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 00 Birthplace (State or Foreign Opunter) 8. Date of Birth (Month, Day, rs last hirthday **Funeral** Min Year 1 1 2 N 2 □ F Months Days Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples 2000. 10d. Inside City Limits State 10h Coun 10c. City, Town or Location 1 □yes 2 □ No Director more 10f. Zip Code 10g. Citizen of What Country? Street and Number Completed by Funeral 00 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 □Yes 2 ▼No Specify. 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathe s Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bister Wood DIME 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 200 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee uneval NOCTH 23a. Part1. Enter the div. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4EARS Physician Lanonary MIGREY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) □Yes 2□No signed by the a 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred jon 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death neral Director: / filled in by the f Certificati 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely (Check only one) Medi and manner stated. To the within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

amend #7 PER FH G886 12/23/08 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7,2008 12:10A December PATRICIA A. Katona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Nottingham 9105 Kilbride Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** Months Days 1 □ M 2 □ F 70 Yrs November 1,1938 Maryland Director 212-36-4943 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f sho event, it a Modical Evanitation at 1 ☐Yes 2 ☐ No Director Nottingham Balto. Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9105 Kilbride Road 21236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 X No White Specify Yes Give Specify ò 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Lillian West Alfred Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1325 LINKOUS Rd. Pylesville, Md. 21132 Mike Katona Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 12-10-2008 Parkville Schimunek Funeral Home 21. Signature of Funda Service Licens 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IEET KIDNEY Immediate Cause (Final VEAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the conditions, if the condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 24 No 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🗆 Nursing Home 2V No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29et Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 29a) (Type, Print) Suite 212 Towson, MD 21204 7505 Dr. 32. Rigistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:23 AM December 16, 2008 Doris Ricko Kordela /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death mo gnes 05 PITAL 2122 TIMORE If Under 1 Year | If Under 24 Hfs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Months 1 □ M 2 🖫 F 217-24-2419 Director 80 29, 1928 Maryland Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2 1X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 237 Edridge Way 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 📉 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 XNo Specify: δ 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Washington King Ana (Dora) Ricko 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. Michele Elder Daughter 237 Edridge Way; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oaklawn Cemetery 12/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Euneral Service Licenses Approximate Interval Between Conset and Death Conset and 490 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Lege **Physician** MASSINE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner evere Ger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician Be Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnation the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) ☐Yes 2 No detached 9 I Inknown signed by Part | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, page 2 should be 2 **Z** No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate SERTENSION 2 No 1 ☐ Yes 1 ☐ Yes Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Medical Certification: To i⊟Yes 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6200 +TTENDING rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 720-C MAIDEN Choice LA NORBERTO M. MACHIRAN

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State	of Maryl	and / Depa <i>Ce</i>	artment o rtificate d				giene Reg. No.	0000	40510
Division	_	1. Decedent's Name (First, Middle	e, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
Physiciai /Medica	_	Wayne Mila	and Luk	enbach					Decembe			7:10 P <sup>M</sup>
Examine		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Tow	n, or Locati	ion of Death		4c.	County of Dea	th
d.		Tate House		T- 4 "		Lint	nicum	der 24 Hrs.	To Date of Div	-41-		Arunde 1 thplace (State or Foreign
Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F		yrs. last birthday)  ∠ Yrs.		ays Hou		8. Date of Bir (Month, Da	ay, Ye <i>ar</i> )	Co	ountry)
Director	-	220-58-1712 Usual Residence of Decedent		) 3	6 Yrs.				June 20	), 19	52   Ma	aryland
/land	Ì	10a. State 10b. County		10c	. City, Town or Lo	cation						10d. Inside City Limits
Mary	ğ	Maryland Anne	Arunde1		Se	evern						1 □Yes 2 🔀 No
h the	Director	10e. Street and Number			-	10f. Zip Co	de			10g. Citi	zen of What Co	ountry?
th wit	<u> </u>	355 Montecrist	o Court				21144			Un	ited St	tates
illed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show ent, the Marical Examirer must be notified at	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever i Forces?	n U.S. 13.	Was Decedent If Yes, specify	of Hispanic Cuban, Mex	Origin? (Sp	pecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whit	
or it	Dy F	1 Never Married 2 Marr	If Vac (	2 □ No Give		1 □Yes 2【X					Specify:	
ural",	D D	3 ☐ Widowed 4 ☐ Divorced		Dates: 197		dent's Usual O	neupation			16h Kii	Wh nd of Business	nite
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filed Hyg other ent,	e e	17. Father's Name (First, Middle,	Last)						ne (First, Middle	, Maiden		
ld be lental ked o	90	Miland D.	Lukenb	ach				Hele	n Mari	lan	Escavag	ge
sh as a sh		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (St	reet and Nu	ımber or Ru	ral Route Numb	er, City o	r Town, State,	Zip Code)
and 2 ealth e n 27 is		Connie Jo Luker	nbach/wif	е	355 N	Montecr	isto (	Court	Severn	ı, Ma	ryland	21144
r of He		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation	O Domewal from	20	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other	f place)		Date	20c. Lo	cation - City or	Town, State
dittillOI rmit. Pages partment of portant: If it y Injury or o		4 □ Donation 5 □ Other (S		n State W	est Aru	ndel Cr	emato	ry 12/	11/2008	00	enton,	Maryland
	1	21. Signature of Funeral Service	Licensee		3	2. Name and A	ddress of Fa	acility neral	Home &	Crem	atory,	P.A.
0 89 E 8 9	D)	Quanty Or	Thoma			411 An	napol:	is Roa	ıd Oder	ton,	Maryla	and 21113
		23a. Part (Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the c	death. Do not en	ter the mode of	dying, sucl	h as cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Me	tasta	tio b	ladde	r	Canc	ex			Onset and Death
/Medical		resulting in death)	Due to	o (or as a con	sequence of):							1.
Examiner	_	Sequentially list conditions,	b. fa	iluse		nive					- 4	195.
pa tis .	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a cor	isequence of).							6 months
and I-tran	xau	that initiated events resulting in death) Last	c. Due to	o le as a cor	sequence of):	order						
ficate be executed physician and sthe burial-transit	<u>a</u>			`	, ,							
ficate ficate phys s the	edical		d									
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pr							23d. Date of de	elivery
death death d for	<u>cia</u>	in the past 12 months?	4 □ Pre	e birth 2□ egnant at time		☐ Ectopic preg ☐ Other (speci					Month	Day Year
by the	Phys	9 Unknown	9 □ Un	known								
s that	by P	Part II. Other significant condition	ons contributing to	death but not	t resulting in the u	inderlying caus	e given in P	art I.	23e. Did	tobacco u	ise contribute t	o the cause of death?
quire an siç	9 P								1 🗆	Yes 2	No 3□ P	robably 4 🗆 Unknown
law requires t as been signe 2 should be c	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
age T	E			-					perfe	ormed? 2 No	death?	s 2 No
vician: The certificate rector, pag	Φ	25. Was case referred to medica		0			26. F	Place of Dea	th (Check only			
ding Physician: The h. After this certificate h funeral director, page	9 0	examiner? 1 ∐ Yes 2 📉No	Hospital: 1 [	Inpatient	2 ER/Outpatie	nt 3□ DOA	Other: 4 [	☐ Nursing H	ome 5 ☐ Res	idence (	6 Other (Spe	ecity) itospice
ng Phy ng Phy ifter this	ä	27. Manner of Death 1	/A A	te of Injury onth, Day, Yea	28b. Time of Injury		Injury at Work?		28d. Describe	how injur	y occurred	•
SION tending leath. tor: Afte the fune	cati	2 Accident investi	gation			М	t □ Yes	2 □No				
or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	20e. Pla	ce of Injury - <i>i</i> Iding, etc. <i>(S)</i>	At home, farm, st bec <i>ify)</i>	reet, factory, of	ice		28f. Location ( City or To	(Street an wn, State	d Number or R )	lural Route Number,
oital o											<u> </u>	
Host 24 ho Fune rtely f	ca	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To t Examiner: On the	basis of exa	/ knowledge, dea mination and/or i	n occurred at t nvestigation, in	ne time, da my opinion	te and place , death occu	e, and due to the irred at the time	e cause(s , date and	) and manner a d place, and du	as stated. e to the cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, I	Medical	29b. Signature and title of certifie		anner stated.		29c. Li	cense numb	ber		29d. Dat	te signed (Mon	th, Day, Year)
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		30. Name and address of person	who completed as	use of dooth	(Item 23a) (Tuno	Print\					1	
1011		MIRZA NUSAR	EE 106	7 ( A. () 2	-TON CE	NIRE	CC	CFTON	19 mo 3	21114		
Stat	e	31. Date filed (Month, Day, Year)	<b>3</b> 2.	Registrar's S	Signature	200				/		
Registra		nerie 2	nne Au		M. Boss							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician ANGSTON DECEMBER 15 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS BAYVIEW INFOICAL CENTER BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) Funeral Days Hours Min. 1 ☐ M 2 🖫 F Jan 10, 1928 NY Director 104-20-3588 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medical Examinationals at 1 TYes 2 □ No N/A Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number be filed within 72 hours after death with USA 21224 3737 East Lombard Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>۾</u> 3 SrWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Eberly Philip D. Bartello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Pages 1 and 2 1908 Snyder Avenue, Baltimore, MD 21222 Angela Rotondo Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 20, 2008Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility 401 South Chester St. Baltimore, M 21. Signeture of Funeral Service kidensee David J. Weber Funeral Homes, P.A. ort 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 mi lmonor /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🕽 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar

29b. Signature and title of certifier

YATES JENNIFER 2. Registrar's Signature 31. Date filed (Month, Day, Year) 18 DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MEDICAL DOCTOR

29c. License number

RES-000

BACTIMORE MARYLAND

29d. Date signed (Month, Day, Year)

DIVISI

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Control Hospital or Attention At

DECEMBER

EDDIE NAKHUDA, M.D. 2300 DULANI
31. Date filed (Month, Day, Year) 32 Registrar's Signature

2008

DEC 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. 2300 DULANEY VALLEY ROAD TIMONIUM, MD21093

re Assilis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11:30 PM 2008 William George McKechnie Dec. 10, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baywoods of Annapolis Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 116-18-7386 81 07-07-1927 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 7101 Bay Front Drive United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \mathbb{X} Yes 2 \subseteq No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medical Doctor Private Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ilth and Ment 27 is marked r traumatic e Willard McKechnie Florence Mannering 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Mary J. McKechnie / Wife 38 Front Street Apt. 4E Binghamton, New York 13905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory:12-15-2008 Odenton, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and s the buriaf-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical led by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No 1 🗆 Yes 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 3 Probably 4 Unknown certificate has been si rector, page 2 should b 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 1 □ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Injury s after death.

Il Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A312 BOMENS 20716 ss of person who completed cause of death (Item 23a) (Type, Print) Mijh, Ilvillerd 251 4000 ave Kol a de

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, DEC 1 8

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year  $\underline{\mathtt{A}}^{\mathsf{M}}$ Physician December 15 2008 2:50 Patrick Robert McGee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 □ F 86 Director 232**-**05-1839 Oct. 31 1922 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2XTXNo Director MD Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6100 Parkway Drive Funeral 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XIYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Census Bureau Printing Specialist 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Patrick Joseph Vella Spragg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 Parkway Drive, Laurel, MD 20707 Elsie Maude McGee/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Pages Department of Important: If its any Injury or o TSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2008 Laurel, MD Mary's Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 Laurel, MD 313 Talbott Avenue, 20707 Approximate Interval Between Onset and Death 23a. Part 1. fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediat Lause (Final Physician Pulmonary Fibrosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any least conditions, if any least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of executed Exami burial-transi Due to (or as a consequence of) nding physician are as the burial Box 68760, certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year ō Month 5 ☐ Other (specify) signed by the a ☐Yes 2☐No o 9 Unknown 9 Unknown 9. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' 1 ☐Yes 2X No 1 ☐ Yes 2 X No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2√∑ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral Certification: After 1 💢 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D64874 December 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1011 21044 Shahab Zare Bavani, 10724 Little Patuxent Parkway, Suite 200, Columbia,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
b per Fh 6887 175709 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mussina Weigold 1:15 P Anna December 15, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dundalk 34 Eastship Road Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 T F 215-22-7820 97 Director Feb. 11,1911 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unty or other than "natural", in marked the taumatic event, Ir. It. Affect Eng. it in must be notified at uny or other traumatic event, Ir. It. Affect Eng. it in must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 □Yes 2€No Dundalk Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21222 34 Eastship Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖫 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: <u>۾</u> 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore County 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Board of Education School Teacher 12 Years 6 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weigold Carrie Sherman Herma n ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) John R. Mussina Department of Health Important: If Item 27 any Injury or other tr. once. Dundalk, Maryland 21222 34 Eastship Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12/18/2008 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2008 Milton, PA Harmony Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility SAR Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 22020No 1 ☐Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2∏XNo Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec. 16, 2008 D0034749 will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland M.D. 2112 Dundalk Ave. Anthony Harrell, 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State DEC 18 Registrar 2008

1 - For State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DR Tamars, Smith
31. Date filed (Month, Day, Year)

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

Completed by

Be

Certification: To

**Physician** 

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinations in collidated.

Physician /Medical Examiner

/Medical

For State Registrar					•		it of Health e of Deat			Reg. No.	201	n R	40	516
. Decedent's Nam						-			2. Date of De Month	ath Day	Table 100	Year	/	of Death
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Facility Name (i	f not institution,	give street and nu					Town, or Locatio			1	County o	-		
RANKLIN	Sauce			Cei		,	ROSedo		0 D-1- 15:		9 -0		101-	
Social Security N		6. Sex 1½∏ M 2□ F	7. Age 89	(In yrs. la	st birthday Yrs.	) If Under Months		er 24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)		Cour		or Foreign
sual Residence of							1		05-02-	1919		Mary	Tanu	
a. State	10b. County			10c. City,	Town or L	ocation.						1	0d. Inside	
arvland	Bal+im/	ore	T	Dunda	1k								1 □ Ye	s 2 <b>∑</b> No
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3 🗆 Widowed	4 Divorced	Year or I		[WW]										_
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Nicholas	Metal						Chr	istina	a D'Arq	enzi	0			
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			~ <i>,</i>		2032	HOTEC	orn Road	Dunda	alk MD	2122	2			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical State

DHMH 17 Rev 1/2001

Registrar

DEC 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



9000 FRANKLIN SQUARE OR

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

065241

29d. Date signed (Month, Day, Year)

Balto md 21237

12-12-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per FH C886 12/29/08 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Janet Lynn Masilek 17,2008 Dec. 11:32aM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 338 Stonecastle Ave. Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 15 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 214-34-486.7 **Funeral** Days 1 ☐ M 2 🖾 F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expirition of the positived at once. 1 ☐ Yes 2 No Director Reisterstown Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 338 Stonecastle Ave. 21136 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Day Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Fort Elizabeth Martin ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1206 Jo Apter Place, New Windsor, Md. 21776 Joe Masilek - Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Dec. 18,2008 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 23a. Part 1. Exter the disease, or complications that caused the death. Shock, or hear failure. List only one cause on each line. 21117 Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) 3-4 weeks **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No ed by the detached i 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1140 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uille 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 18 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician DONINA MCNEW PARKS December 18, 6:05A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 🗌 M November 2,1939 69 Washington DC Director 220-36-3225 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or items 23a or 28a-f show the Medical Evanings rough by notified at 1 ☐ Yes 2(X) No Director Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with USA 21212 209 Murdock Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 277 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐Yes 2XXNo altimore, Maryland 21215-0036 lf Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, I'm Media once. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Brown Cecil Lee McNew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2490 Wentworth Road Baltimore, Maryland 21234 DTR Anne Stevenson Parks 20a. Method of Disposition

1 ☐/Burial 2 ☐/Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 19, 2008 | Baltimore, Maryland GreenMount Crematory 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc cnature of Funeral 50 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VAZUAN Physician COVS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed ending physician and use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? certificate of Vital : After this certifica e funeral director, r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSP ( 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural Accident 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? Certification; Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier December 18 2008

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANKS



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# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Examine	er	4a. Facility Name (/ Genesis E					entei	r	4b. City,		r Location nda l	on of Death _k		4	c. County Ba.	of Death <b>ltim</b> c	re	
Funeral		5. Social Security N	lumber	6. Sex		. Age (In yr	s. last bir	thday)	If Under	1 Year Days	If Und	der 24 Hrs. s Min.	8. Date of E (Month, I March	irth Day, Yea	Cha	9. Birthp	lace (State o	r Foreign
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any injury or other traumatic event, Its Medical Exagnce.		20a. Method of Dis 1 X Burial 2 I 4 ☐ Donation			noval from S	20b tate Sac	Place o cemete	of Dispos ery, crem <b>teart</b>	sition (Nar natory or o	ne of ther place	ce) Cem.	Dece	mber 2008		Location - ndalk		wn, State yland	
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To the	Examiner	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nditions, nmediate erlying	Į "	Due to (o	r as a cons	equence	of):	<i>C</i> •	. A								
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[ 9 ☐ Unknown	2 months? □ No	230		rth 2 ☐ Fe ant at time o	etal death		Ectopic p Other (s		су				23d. Dat Mo	e of delive		ear
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ding Physi h. After this of funeral dire	2	1 ☐ Yes 2 ☐ 27. Manner of Deat		HOS	spital: 1 ☐ In 28a. Date o	patient 2	_	utpatien Time of		OA Oth 28c. Injui	4	Nursing H	lome 5 Re				y)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year PANDYA **Physician** JUGALMANI DEC 2:45 2008 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 20809 Merle Drive Gaithersburg 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🗓 F 87 Sept. 14, 1921 India Director 578-92-1302 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Experience rough by nothing at 1 ☐ Yes 2 🔀 No Funeral Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 20809 Merle Drive India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: <u>م</u> 3 X Widowed 4 ☐ Divorced Asian Indian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 6 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Javalxmi Sevak ပ Sunderlal Madnji Mehta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) . Pages 1 and 2 sho ment of Health and lant: If item 27 is m 20809 Merle Drive Gaithersburg, Maryland 20882 Department of Healtt Important: If item 27 any injury or other to Priyakant K. Pandya / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 12-13-2008 W. Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANCER OVARIAN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 5 ☐ Other (specify) P.0. the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has by page 2 s autopsy performed' certificate 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 00061083 DEC. 12,2008 Medical Center Dr. #300. Rockville, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

DEC

18

2008

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 10:43 A M December 17, 2008 <u>Lenore Marian</u> Pfeiffer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🕱 F 85 13, 1923 Pennsylvania Feb. Director 179-18-8856 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 1305 Blossom Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates 1 □ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ⁴ be ₁ and Mental Marion Irene Bailey Arthur Paul Peters ဂ္ 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Peter J. Pfeiffer / Husband 1305 Blossom Drive, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12-18-08 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

McComas Funeral Home, P.A 21. Signature of Fineral Service Licensee Markle m 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications, or heart failure. List only on cause on each line. Immediate Cause (Final Shock Physician CARDIOGENIC TWO DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYOUARDIAC INFARCTION TWO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68力 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 10 1 □ Yes 2 🕶 😘 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier DO056296

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar Upper Chesapeake Drive Bel Air, MD 2014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Birnbau

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g88612-18-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month Day **Physician** Yersian. W:W (A) a 12 3 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Baltimore Daylen larela showith (V/W CP CITO Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 270 14 1583 1 ☐ M 2 💢 F 5 PA. 122/19 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Maryland Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3307 Dundalk Avenue 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽIXNo Specify. Specify: Be Completed by 3 Widowed 4 □ Divorced White "natural", er than "natur 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10 Years Homemaker Own Home Ith and Mental Hygies 27 Is marked other the Traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph LaRosa Mary Yaccino 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Mr. Carl J. Persiani (Son) 3427 Loganview Drive Dundalk, Maryland 21222 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State Holly Hill Mem. Gdns, 12/17/2008 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 001 23a. Part 1. Enter the disease, or complications that caused the demth. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter throughing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 헏 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 10No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation after death.

Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OUU

DHMH 17 Rev 1/2001

State

Registrar

21224

30. Name and address of person who completed cause of death (Item 28a) (Type, Pring

2008

31. Date filed (Month, Day, Year)

DEC 18

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Evelyn 16 2008 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care of Dulaney Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2□F Director 214-14-1853 87 June 15 1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2 ☐ No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be. 111 West Road U.S.A. 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ X☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Shift Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Setlak Frank <u>Anna</u> Kaniecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a t: If Item 27 is y or other tran P.O. Box 38115 Baltimore, Maryland 21231 Philip Ravita (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Stanilaus Cemetery 22,2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses w. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Onset and Death Immediate Cause (Final **Physician** Atherescleration Cardo viscilar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner demontion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death signed by the aid d be detached for 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autonsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death. within 2

the filled in by completely

4 Homicide

29a. Certifier

Medical

(Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier min - Dan Kindins 031865 12/18/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kioune M.D. 821 N. Eutaw Street 206 Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month 11:50 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner sactimore Medical Cente Wid If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F 50 Director 025-40-1680 10-31-1958 Massachusetts Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show the Medical Examiner hast be notified at Director 1 ☐ Yes 2 No MD Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8528 Pine Meadows Drive 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evantionappe. Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Library Clerical Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Mossali ပ္ John Crovo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Rogers / Husband 8528 Pine Meadows Drive Odenton, Maryland 21113 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 12-17-2008 Odenton, Maryland of funeral Service Linense Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (monon disease or condition resulting in death) UKKNEUN /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ils certificate has director, page 2 s 1 Yes 2 12 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated ignature and title of certifier 29b. 29c. License number Cesident Physicia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Rosenbae wa

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40525 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shep **Physician** Month Year a.26 p 2 Sm una 2008 December 5 /Medical 4a Facility Name (If not institution, give street and number)
BAI timore Washing ton
Medical Center Examiner 4b. City. Town, or Location of Death 4c. County of Death BURNIE ANNE ARUNDEL 5. Social Security Number GLEN If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Mooth) Day 3 (Par) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 127-44-4820 XXM 2 F Country yana 71 Yrs Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mariten Examines must be notified as Director MD Anne Arundel Odenton 1 ☐ Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1628 Annapolis Rd. 21113 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineer Mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Shepherd Iatha Beckles ျှ 19a. Informant's Name/Relationship (Type. Print)
Claire Shepherd Wif 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1628 Annapolis Rd. Odenton, MD 21113 Wife Odenton, MD 21113 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 12/18/2008 Baltimore, Maryland
22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any least to be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed UUSUAY and burial-tran Box 68760. physician s the burial Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a P.0. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? Completed by cate has been si page 2 should b 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vital 1 □ Yes 2 110 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To of this 1 inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 tite of certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 00022 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Dr. Glen Burnie, MD 2106/ 305 STUOF mp Jacons 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	-	epartment of F Certificate of		Mental Hy	giene Reg. No2 0 0 8	10526
	Physicia		Decedent's Name (First, Middle, L.  DWIGHT	MURRAY	SU	LLIVAN, S	SR.	2. Date of De Month DECEME	Day Year	
1	/Medic Examin	-	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Deat		4c. County of De	ath
13.5		Ш	MANOR CARE NUI 5. Social Security Number 6.		LLTY  (In yrs. last birth		SSVILLE If Under 24 Hrs	8 Date of Bi		I'IMORE irthplace (State or Foreign
5	<ul><li>Funeral</li><li>Director</li></ul>			1₩ 2□F	77 Y	Months Days	Hours Min.	8. Date of Bi (Month, Di	931 VI	RGINIA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryi I-f eho	tor	MD BAI	TIMORE		ROS	SEDALE			1 ☐ Yes 2 ☐ No
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	eath w	Funeral	2364 HAMILTOWN	VE CIRCLE	ver in U.S.	13. Was Decedent of I	21237	Specify Yes or N	U.S.A.	nerican Indian,
326	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or liems 23a or 28a-f ehow maric event, the Madical Examinar must be notified at	by Fun	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □XYes 2 □ N If Yes, Give Year or Dates: ]	lo	If Yes, specify Cub	an, Mexican, Puèr Specify:	to Rican, etc.)	Black, Wh	white, etc.
21215-0036	72 hou natura		15. Decedent's l	Education	16a. 0	Decedent's Usual Occu Give kind of work done	during most of wo	rkina	16b. Kind of Busines	s/Industry
121	filed within 72 Hygiene. other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use retire	RACTOR		HOME TMI	PROVEMENT
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ylan	should be nd Mental marked o	To B	TJ	SULL	IVAN		ALICE	E MAE	(BOXL)	EY)
Maryland	a = a	i g	19a. Informant's Name/Relationship THERESA SULLIV		- 11	Mailing Address (Street 64 HAMIL)			ner, City or Town, State  ROSEDALE	
	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other pla	I	Date	20c. Location - City	
altimore,	0 0		X⊠Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	ROSARY CE	· 1	19-08	DUNDALK	, MD
Balt	permit. Page Department Important: II eny injury o		21. Signature of Funeral Service Lice	ensee		22. Name and Addre 1211 CHE			SEDALE FU SEDALE, MI	UNERAL HOME D 21237
* 3	# 24. # 24. #		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused y one cause on each lin	the death. Do no	ot enter the mode of dy	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aA	scry	D.				
3	Examiner			b Due to (or as a	a consequence of	1).				
	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of	f):				
J 	ficate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of	f):				
8760	ate be nysicie he bur	dical		d.						
9	certifica ding pt se as t	0	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d Date of o	leliver.
. Box	death certifii e attending p od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □Live birth 4□Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of d Month	Day Year
<u>о</u>	that the de led by the a detached i	Phys	9 Unknown  Part II. Other significant conditions	9☐ Unknown	ut not reculting in	the underlying enuce as	une in Bart I	23e Did	tobacco use contribute	to the cause of death?
Records,	w requires tha been signed should be det	ted by	Faith. Other signmeant conditions	commutally to death bu	A not resulting in		ven at raiti,		Yes 2 □ No 3 □	1
	e la has	Completed						24a. Wa auto perf 1 Yes	ormed? prior to	autopsy findings available o completion of cause of
/ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	Ha saidala		100		ath (Check only		
6	this al di	To	1 ☐ Yes 2 € No 27. Manual of Death	Hospital: 1 ☐ Inpatie		patient 3 DOA			how injury occurred	pecify)
0	nding I ath. r: After e funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day		jury Wo	rk? ]Yes 2 □No		. ,	
Division of Vital	ospital or Attendors after death hours after death uneral Director: ly filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	be d 28e. Place of Inju- building, etc	ury - At home, fari c. (Specify)	m, street, factory, office			(Street and Number or own, State)	Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C		Physician: To the best of miner: On the basis of and manner sta	examination and					
	To the H within 24 To the Fi complete	Me	29b. Signature and little of certifier			29c. Licen			29d. Date signed (Mo	
).			by WD	0.01.40		PSZ	727		19 -10.	- 08
	10		30. Name and address of person wh	Impleted cause of de	eath (Item 23a) (1	Type, Print) Walth	am Wo	ods la	12-16.	1021234
被抗	Sta	ite	31. Date filed (Month, Day, Year)	AND.	ar's Signature	A 4 A				
	Regist	rar	DEC 1 8 2	2008 Barrer		Acoek 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 | 9 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:00 P M **Physician** Herbert James Scism December 2008 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Square Hospita Franklin osedale 8. Date of Birth (Month, Day, Jan 28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 244-36-3616 1 **M** 2 □ F 79 NC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 708 Mace Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of College (1-4or 5+) Elementary/Secondary (0-12) Maryland Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Scism Lillie Mae Grigg ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 708 Mace Ave. Baltimore MD 21221 Maryrose A. Scism /wife permit. Pages 1 an Department of Healt Important: If Item 2 20b. Place of Disposition (Name of Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other Holy Redeemer Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Md 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner he law requires that the death certificate be executed for use as the burial-tran attending physician and to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Tyes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural Injury ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12-16-08 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Prive Baltimore Mp. 21237 9000 Frankli Robert

State Registrar 31. Date filed (Month, Day,

Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:15 PM DECEMBER 2008 Ann Sautter 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner KAUTEMORE AGNES Ktosp estal N/A If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 06/21/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 1 F 195-18-6343 PÁ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No MD Baltimore Halethorpe Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5600 Chelwynd Road 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ž ☐ No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tony Molinsky Christina Sparks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. George E. Sautter (Son) 5600 Chelwynd Road, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State Cedar Hill Cemetery 12/19/2008 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Madet: 4107 Wilkens Avenue, Baltimore, Maryland 21229 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, istemly one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LNTRA HEIDORRHAGE CEREGRAL /Medical Due to (or as a consequence of) DAY **Examiner** Sequentially list conditions, in any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION ATRIAL 2☐No 3☐ Probably 4☐Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AUTTER, AND

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State DEC 18 Registrar

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST AGNES HOSP ETAL.

29c. License number

P21227

BACTEMORE

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** December 5:50 P M Elizabeth W. Simpson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Augsburg Lutheran Home Lochearn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 90 214-12-1594 Maryland Sept.22, 1918 Director Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a. State show d other than "natural", or items 23a or 28a-f show event, the Medical Evaminatinast building at Maryland Baltimore 1 ☐ Yes 2 No Lochearn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6811 Campfield Road 21207 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed who and Mental Hygies Is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Wills Margaret Mary Hamilton ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 308 W. Riding Drive; Bel Air, MD Donald J. Simpson, Jr. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/18/2008 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature Funeral Service I 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Previnouis Immediate Cause (Final Physician Z weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examine the burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760, ding physician certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) TYPES NO P.0. detached 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending F after death. I Director: After d in by the funera Division 5 Pending investigation 1- Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital of thin 24 hours at the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 16,2008 037573 30. Name and address of person who completed cause e of death (Item 23a) (Type, Print) Reisterstam 21134 25 Mari 2 bel MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 18 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** TRIVIDAD 8:40 AM 14 2000 Decembes /Medical 4a. Facility Name (If npt institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tal Baltimor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** April 27, 1958 Months Days Hours Min. 1 M 2 □ F 50 220-31-8062 Philippines Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Walfael Examiner mant be refifted a once. MD Baltimore Middle River 1 ☐ Yes 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9705 Selfridge Road 21220 Philippines 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 TXNo Asian Specify Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Electronics 4yrs 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrado Trinidad Corazon Gulapa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cita Velasco 9606 Redwing Drive Perry HAll MD 21128 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 12/19/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Rectail **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be detached for use as the burnarial. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 2 No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1.XNatural 5 Pending 1 Yes investigation 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral L 29a. Certifie 12 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December, 14/2008 KES 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEID MEHDI JALILI Baltimor, , 3001 3 Hanvier ST,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan	•	artment of F		and M	_		2009	2 1, 0	153
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Mary .	/Medic		4a. Facility Name (If not institution			avera .	4b. City. Town, or		of Death	Decem		County of Death	1.40	
	Examin	er	Crofton Conval		· ·	Center	Crofton					ne Arun	del	
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State o	or Foreign
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fter d	ritem	Funeral	<ul><li>11. Marital Status</li><li>1 □ Never Married 2   Married 3   Married 3   Married 4   Married</li></ul>	Armed F ried 1 ☐ Yes	orces? 2 🏹 No		Was Decedent of H If Yes, specify Cuba			lican, etc.)		Black, White,		
of 17.12.13-1000 filed within 72 hours after death with the Maryland Hydiene.	al",o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 □Yes 2 X No	Specify:				Specify: Whi	te	
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y I Wer	narke	은	Alexander Pri			T				a Scui		~ 0		
12 st th an	7 is r traur		19a. Informant's Name/Relations  John E. Tomas:		1150		ng Address (Street Point Lo						,	
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Phy	sician	. 3	Immediate Cause (Final				small bow					-	Onset and I	Death
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ecute	ind trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c										
be executed	sician and burial-transit		resulting in death) cast	Due to	(or as a conseq	uence of):								
ate	the the	dical		d								-		
Sertifi C	ding l	Physician/Me	IF FEMALE:	230 If yes or	utcome of pregna	ancy						Tire side		
ath o	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2  Feta	al death 3 [	Ectopic pregnanc Other (specify)	У			2	3d. Date of deliv Month	-	Year
j eg	/ the	ysic	1 □ Yes 2 ⊠ No 9 □ Unknown	9 Unk		Jean 5L	_ Other (specify/ _							
that	ed by detar		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco us	se contribute to t	he cause of c	death?
uires	n sigr id be	d by	Dementia							1 🗆	Yes 2	No 3□ Pro	bably 4 □ l	Unknown
9 ≥ 2 ≥	shou	Completed								24a. Was	an	24b. Were auto	psy findings	available
he la	te has	ᄩ								auto perfo	psy ormed? 2. No	24b. Were auto prior to co death?		ause of
an: la	tifficat tor, pa	BeC	25. Was case referred to medical		35.47 = 3535 3439 53	e sanarye		26. Place	of Death	1 □Yes (Check only o		1 □ Yes	2 LINO	
ysici	is cel direc	70 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth					☐Other (Speci	fy)	
- B	ter th neral	Ë	27. Manner of Death		e of Injury nth, Day, Year)	28b. Time o				8d. Describe			,	
ath.	r: Af ne fui	atic	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	, 22),	,,		Yes 2□I	No					
r Att	irecto n by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   Zoe. Flac	e of Injury - At h	ome, farm, str	eet, factory, office		2	8f. Location ( City or To	Street and wn, State)	d Number or Run	al Route Num	ıber,
pital o	illed i		and a street of the street						1	and done he all a	/ - \			
Hosj 24 ho	To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as i	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the	basis of examinations basis of examinations between the basis of examinations are stated.	ation and/or in	vestigation, in my o	ppinion, dea	ath occurre	ed at the time,	date and	place, and due t	o the cause(s	3)
o the	o the	Mec	29b. Signature and title of certifie	r	Tiller stated.		29c. Licens	e number			29d. Date	e signed (Month,	Day, Year)	
<b>⊢</b> ≶	~		Almil	12en	en M.		D002	9571			12	115/2	2008	/
16	. 0		30. Name and address of person	who completed car	se of death (Iter	n 23a) (Type.						/ /		
			Paul B. Berez	, M.D.	2225 E.	Defen	se Highwa	y, C	Croft	on, Ma	rylan	d 21114		
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	A s							
	Registr	ar	DEC18	2008	was Di	1600	The state of the s							

## Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician DECEMBER EDITH PROCTOR TILLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2814 Falls Mont Drive Fallston 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Months Davs Hours 1 □ M 2 🛛 F Yrs 24, 218-32-8789 73 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director Maryland Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2814 Falls Mont Drive 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2**½** No f Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: ò 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriet Lois Terry Richard Rogers Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Larry G. Tilley / Husband 2814 Falls Mont Drive, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 12-17-08 Bel Air, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. Kusa 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Leiomyosarcoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 certificate has been si rector, page 2 should Completed 24a. Was an 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death Certification:

and manner stated.

32. Registrar's Signature

20

30. Name and address of person who completed cause of death (Item 23a) (Type,

2008

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform<u>ed</u>? 2 **X**No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 12-15-08 401

Year

1935 Maryland

Race - American Indian, Black, White, etc.

White

4:30 P

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

2008

4c. County of Death

Harford

Specify:

Own Home

13,

State Registrar

Medical

1 🔀 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

David

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

Ettinger Year) I8

neral Director: /

n 24 hou. the Funeral D

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 10:46 A<sup>M</sup> Whye 2008 James Howard December 16, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 XM 2 ☐ F Director Nov 27, 1934 Maryland 219-30-0224 74 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show adion Examiner must be nutified at 1 XYes 2 ☐ No Director N/A Baltimore City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21214 6301 McClean Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White th and Mental Hygiene.
7 Is marked other than "natur traumatic event," he medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Gov. 10 n/a Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fil Mental F Watkins **Gladys** Norris ည Wilbur Pages 1 and 2 shou ment of Health and M ant; If item 27 Is mar ury or other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6926 Dogwood Road, Windsor Mill, Maryland Lucinda Whye/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) St. Lukes Cemetery 12/22/08 Hereford, Maryland ure y Funeral Service Lich see Bryan W. Clary 22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley Inc.

10 W. Padonia Road, Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate ause Final disease or will n **Physician** eal CANCER ESU mhot disease or resulting in death) /Medical Due to (or as, consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): 68760, Physician/Medical nding p IF FEMALE: Box attendin for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) o been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 3 Probably 4 Unknown 1 ☐ Yes Record has been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 🗆 No 1 ☐ Yes Vital Physician: 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 14Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) les St. Balto Md

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 9, 2008 Physician T. Amberman, Sr. 3:10 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1121 Old Philadelphia Rd. Aberdeen Lot 47 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 10/15/1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 15 M 2□ F Pennsylvania Director 217-36-3179 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Harford Aberdeen MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1121 Old Philadelphia Rd. Lot 47 21001 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 MayYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Key Point Health Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Amberman 2 Mina Bulette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aberdeen, MD Edward E. Amberman (Son) 3416 Nova Scotia Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/12/08 Bel Air Mem. Gdns. Bel Air, MD 21. Signature of Funeral Service/Dicensee 22. Name and Address of Facility Tarring-Cargo Funeral Home Aberdeen, Maryland 21001–
23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metaltotic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed To the Hospitef or Attending Physician: The law requi within 24 hours after death.
To the Funeral Director: After this certificate has been s 24b. Were autopsy findings available prior to completion of cause of doub? 24a. Was an autopsy death? 1 ☐ Yes 2 -NO 1 Yes 2 - NO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Atl

State Registrar A, M Source
31. Date filed (Month, Day, Year)



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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12/10/2008

08-09244	
Debra Abbott	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day December 9, 2008 0031 hrs Medical Examiner DEBRA L. ABBOTT 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Preston Caroline 22986 Westview Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year If Linder 24Hrs. 5. Social Security Number 214-6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Director OCT 21,1959 Country) MD 49 <del>216</del>-68-6822 1 M 2X F Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No PRESTON CAROLINE MD Director 10g, Citizen of What Country? 10e..Street and Number 10f. Zip Code 21655 USA 22986 WESTVIEW DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11: Marital Status White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No 0 f Yes, Give Year Yes 2X No specify: 4 X Divorced Specify: WHITE 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " traumatic event, the Medical HEALTH CARE CERTIFIED NURSING ASSISTANT 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DONNA PARKINSON Be GUIFORD ABBOTT, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 24314 RICHARDSON ROAD, FEDERALSBURG, MD 21632 DONNA ABBOTT/MOTHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition or other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/16/2008 EASTON, MARYLAND SPRING HILL CEMETERY Donation 5 Other Specify 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee Tramb Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Cardiac arrythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Biventricular hypertrophy with myocardial fibrosis Sequentially list conditions, Due to (or as a consequence or) Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Records, P.O. Box 68760, The law requires that the death certificate be executed? Due to (or as a consequence of) events resulting in death) Last n and transit Pi line a-b, Pll,2/,per ME #5 per FH G 886 12/24/08 TT Physician/Medical ,G886 12/23/08 TT X UNPENDED AMENDED the attending physician ed for use as the burial Records, P.O. Box 68760, 23d, Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 V Unknown Pulmonary granulomatous inflammation Completed 24a. Was an 24b. Were autopsy findings available page 2 should prior to completion of cause of autopsy After this certificate has funeral director, page 2 sl performed? death? Yes 2 No No 1 1 Yes I or Attending Physician: after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical within 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

OCME

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year)

8

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 10, 2008

08-09243 Robin Armour

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 40537"

		For State	i wai yiana / E	Certificate o	f Death		Reg.	No.	
Physiciar	1/	. Decedent's Name (First, Middle,Last)	11 13 12 12				Date of Death     Month	oay Year	3. Time of Death
ledical Examin		Robin Le		mour	4b. City, Town, or L	, , ,	December 9	4c. County of Dea	0937 hrs
	ľ	a. Facility Name (if not institution, give s 6565 James Lee Drive	street and number)		Hughesville I	*	the period	Charles	•
Funeral	14 14	Social Security Number 6. Sex	7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Birth (	MM/DD/YYYY) 9. B	
Director		215-06-6897	4 2 X F 2	5 <sub>Yr</sub>	Months Days	Hours Min	10/05/	1983 Fore	ign ountry)Mary1and
1 1 407 J. W		Jsual Residence of Decedent							
w any	1	0a. State 10b. County	10	c. City, Town or Loca					10d. Inside City Limits  1 Yes 2 X No
aryland 8a-f show at once.	١٤	Maryland Charles  Oe. Street and Number		nugn	esville		I 100	. Citizen of What Co	
after death with the Maryland all, or items 23a or 28a-f sho	Director					( ) 7	109		· ·
W = 23		6565 James Lee D	T1ve 12. Was Decedent Ev	er in U.S. 13. W	as Decedent of Hisp	637 anic Origin? (S	pecify Yes or No-	U S	A erican Indian, Black,
item item	Funeral	1 Never Married 2 XXMarried	Armed Forces?	- If	Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc.	
after d	by F	3 Widowed 4 Divorced	F Yes, Give Year	1	Yes 2 X No	specify:		Specify:	White
		15. Decedent's Education (Specify only	highest grade comple		ent's Usual Occupation of working life.			6b. Kind of Business	s/Industry
36 in 72 han "dical]	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Di	sabled			Disab	led
d with	ᇹ	17. Father's Name (First, Middle, Last)		l	1	8.Mother's Name	e (First, Middle, Ma	iden Surname)	
21215-0036 und be filed within 72 hou marked other than "nat in event, the Medical Experience."	Be	Robert Kenyon	Armour		2710020-0922	Barbara	a Lee	Loef	fler
	٥١	19a. Informant's Name/Relationship (Typ		4.7	•			er, City or Town, Sta	
~~~ 🥌 전 등 표 🚽 ~	-	Robert Armour/Fat	her		James Le		·	ille, MD	
Baltimore, Moemit: Pages 1 and 2 Department of Health Important: If item 2 njury or other fraur		1 Burial 2 X Cremation 3	Removal from State	crematory or o	other place)			ŕ	·
tin Pag		4 Donation 5 Other Specify: 21. So ature of Funeral Service License	200	Brinsfie	ld-Echols	of Facility	/11/2008	Charlott	e Hall, MD
Balti permit: Departm Importa		Mark to Della Victoria	M00	817 $\frac{B}{3}$	rinsfield	-Echols	Funeral	Home, P.A	11, MD 2062
Physician	-	23a. Part I. Enter the disease, or complice failure. List only one cause on each	cations that caused the	e death. Do not enter	the mode of dying,	such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical *xaminer		Immediate Cause (Final disease a	Methadone	and oxyc	odone int	oxicati	on ·		Death
,		or condition resulting in death)	ue to (or as a consequ	ience of):					3
	ē	Sequentially list conditions, b if any, leading to immediate D	ue to (or as a consequ	uence of):		100			
	티	cause. Emer Underlying Cause (Disease or injury that initiated							
Mg-iransit	Щ	events resulting in death) Last  d.	ue to (or as a consequ	ierice or).					
a a a c	Medical	X UNPENDED	AMENDED 23a	,27,28a-f	, perME ,	G886 12	/30/08 TI		
		F FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of delive	·
68° certificanding	ician/	3b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tim	as of donth	Fetal death 3 L  Other (Specify)	Ectopic pregn	ancy	Month	Day Year
Box 68's death certificate attending	S	1 Yes 2 No 9 V Unknown	9 Unknown	5 (	Iner (Specify)				
P.O. Box 687 ss that the death certifi- gned by the attending the detached for use as t	by Phy	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	ven in Part I.			to the cause of death?
S, P.C	돃								obably 4 🗹 Unknown
cords, I	blet						24a. Was ar autopsy perform	prior to	autopsy findings available completion of cause of
Rec The la	Completed						1 ✓ Yes 2		
Division of Vital Records, and or Attending Physician: The law requirers after death.  al Director: After this certificate has been in the funeral director, page 2 should be an in by the funeral director, page 2 should be a should be	Be	25. Was case referred to medical examiner?	spital:			of Death (Check		esidence 6 🗸 Oth	
f Vi Physi er this	라	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatie	. 0	y at Work?		esidence 6 V Otr	er: Scene
nding Ph nding Ph th.	ë	1 Natural 5 Pending	(Month, Day,Yeer	)	1 V	es 2 X No	unk	,.,	
ivision or Attenc after death Director:	lica	2 Accident Investigation 3 Suicide 6 X Could not be	OO - Diseas of laive	/08 Fd 9: y - At home, farm, str		uilding, etc.	28f. Location (St	reet and Number or I	Rural Route Number, City
Divis Hospital or At 24 hours after d Funeral Direct	Certification:	Suicide 6 X Could not be determined  4 Homicide	(Specify) F	d: reside	nce		or Town, Sta Hughesvi		mes Lee Dr
			n: To the best of my k						
To the How within 24 h To the Fur	<u>ت</u> ا		On the basis of examir and manner stated	nation and/or investig	29c. License				
	2	29b. Signature and title of certifier	115		O.C.M			29d. Date signed (A December 10,	
	-	30. Name and address of person who co	ompleted cause of doc	th (Item 23a)					
			edical Examiner		eet, Baltimore, I	MD 21201			
Sta	ite	31. Date filed (Month, Day, Year)	Registrar's	Signature	<b>a</b> 0 .				
Registr	ar	DEC 1 8 2008	All the second	the Good					
DHMH 17 Rev 1/200	01		da.	ŐRIGIN.	AL			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11/29/2008 1505 ANDERSON /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/31/1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 248-40-4252 76 SUMTER, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director DC WASHINGTON, DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3298 FT. LINCOLN DR. N.E. #424 20018 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 M No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6TH TAXI DRIVER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN JULIA ANDERSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #205 WASHINGTON, 20c. Location - City or Town, State DC20008 DEBORAH ANDERSON/ DAUGHTER 4550 CONNECTICUT AVE. N.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WASHINGTON NATIONAL 12/6/2008 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND, MD 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Fungral Service Licens 716 KENNEDY ST. N.W. WASHINGTON, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HTN Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Embours M ospital or Attending Physician; The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and ily filled in by the funeral director, page 2 should be detached for use as the burial-transit LMONART Due to (or as a consequence of) Box 68760, 000 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 □ Yes 2 □ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2√□No 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 → Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide h. an 24 hour. **he Funeral Dir.** الا filled in bv determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

32. Registrar's

RANDALL WAGNER, MD

31. Date filed (Month, Day, Year)

D004495

7600 CARROLL AVE.

80

TAKOMA PARK, MD 20912

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26<u>,</u> **Physician** 2008 8:50 P M November Gordon Albert Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 6. Date of Birth (Month, Day, )
June 16, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Year Hours Months Days 1X M 2 □ F 1926 Maine 82 Director 718-01-3960 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD Anne Arundel Edgewater 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21037 1515 Shore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1;☐Yes 2 ☐ No If Yes, Give Year or Dates: 1948–67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ò 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy <u>Civil Engineer</u> 16. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Viola Sandstrom Albert Andrew Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823-F Stratford Way Frederick, MD 21701 Kevin Anderson/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/05/08 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a. Pneumonia Omt /Medical Due to (or as a consequence of): Examiner h Scosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 힏 or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transi Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 0 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fracture of C-2 and C-3 vertebra 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should traumatic brain injury 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed?

1 Yes 2 XNo 1 ☐Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1X∏Yes 2∐No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 08/28/08 1 ☐ Yes 2 No 4:00 AM fell down flight of steps 2X Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*friend's home determined 4 Thomicide 923 Old Piseco Rd. Piseco, NY To the Hospital within 24 hours a To the Funeral C the Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier roughthou, ms 20063748 Jacetyne November 27, 2008 logi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 5 2008

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland	•	artment <i>rtificate</i>			nd Mer		giene Reg. No. 2	008	4054	0
	Physicia		1. Decedent's Name (First, Middle, Las Robert Glenn Aher						2	Date of Dea Month	Day	2008	3. Time of Death	
0	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give		ast birthday) Yrs.	If Under 1		Plate Under 24	Death			9. Birth	nplace (State or Foreign h Carolina	n
	ryland show		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo								10d. Inside City Limits	
1±84h	death with the Maryland ms 23a or 28a-f show r.mst be notfined at	Funeral Director	Maryland Char 10e. Street and Number 12828 Lemand Lane	les	Wal	10f. Zip (	Code 601				-	of What Cou	1 □ Yes 2/1 No untry?	
2-46 136	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at once.	<u>م</u>	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decede If Yes, speci	ent of Hispa fy Cuban, I	anic Origin Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)		Race - Amer Black, White, ecify: Whi	, etc.	
MR- 1215-0036	within 72 hou ene. than "natura the wedical E	Completed	15. Decedent's Ec (Specify only highest gra-	lucation	(Give life.	dent's Usual kind of work DO NOT use nator	( done durii e retired)	ing most of	f working	- 1/4		of Business/li		
Sebert Maryland 2	uld be filed v Aental Hygid rked other tic event, the	To Be Co	17. Father's Name (First, Middle, Last) Joe William Ahero		20011			3. Mother's	,	rst, Middle, ickma	Maiden Sur	rname)		
Mary Mary	and 2 shousalth and N 27 Is mai		19a. Informant's Name/Relationship ( Barbara Aheron/ W	• • • • • • • • • • • • • • • • • • • •	19b. Mailir 12828	ng Address 3 <b>Lema</b>	nd La	Number o	or Rural Re Aldor	oute Numbe f, Ma	r, City or To	d, 206	01	
Baltimore	Pages 1 a transment of He tant: If item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y) Trin	lace of Dispo emetery, crer nity Me	em. Ga	rdens		Date C. 5,	2008		orf,M	Town, State lary land	
PSKC Balt	permit Depart Import any Inj once.		21. Signature of Funeral Service Licer  Aller A	us roos	-4 431		d Was	shing	ton F	ld. Wa			20601	
	cate be executed /Medical Examiner the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	hear	I s	lize				- 4	Approximate Interval Between Onset and Death	
	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	⊒ Ectopic pr ⊒ Other (spe					23d	. Date of deli Month	very Day Year	
rds, P.	w requires that the de been signed by the should be detached	ğ	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying ca	use given i	in Part I.					the cause of death?	1
al Reco		Completed							_	24a. Was autop perfor 1 □ Yes	rmed? 2  No	prior to c death?	topsy findings available completion of cause of	9
of Vit	ding Physician: th. After this certificant in the director, it is the director.	To Be	25. Was case referred to medical examiner?  1D Yes 2 □ No	Hospital: 1 ☐ Inpatient 2.☐			A Other:	4 ☐ Nursi	ing Home		lence 6	Other (Spec	pify)	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death  T Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not b determined		28b. Time o Injury	М		t s 2 □ No ———			Street and N		ral Route Number,	
	e Hospitu 24 hours e Funera	Medical (	29a. Certifier (Check only one)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred anvestigation,	at the time, in my opin	date and lion, death	place, and occurred	I due to the at the time,	cause(s) an date and pla	id manner as ace, and due	stated. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	n. Tayar	-in	) 29c.	License no	umber	583		29d. Date s	igned (Month	, Day, Year)  + Neo X	
	136		30. Name and address of person who 11655 with 4 31. Date filed (Month, Day, Year)  DEC 0 4	completed cause of death (Item	23a) (Type,	Print)		MB		2060	46.4	AHIA	TAGOUURI, M.	D.
	Sta Registi	ite ar	31. Date filed (Month, Day, Year)  DEC 0 4	2008 32. A gistrar's Signa	turg /	bark	p.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harold Pershing Byrd 1:40 P M December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Days Hours Min. 1 <del>Q</del> M 2 □ F 89 213-18-9733 Maryland Director Aug. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location f show item 27 is marked other than 'natural', or items 23a or 28a-f shot other traumatic event, the Modical Examination until be notified at 1 ☐ Yes 2√ No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 U.S.A. 21712 Leitersburg Smithsburg Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∑Yes 2 No 1941-If Yes, Give Year or Dates: 1946 Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ğ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Trucks Assembly Line 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amanda Virginia Babington David Isiah Byrd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $21\overline{742}$ 19a. Informant's Name/Relationship (Type. Print) 21712 Leitersburg Smithsburg Rd. Hagerstown, MD Margaret C. Byrd (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition rof F 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State December ö Department of Important: If any injury of once. 13, 2008 Locust Grove, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a contaguence of) Examiner phic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1∐Yes 2∐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case riferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HO 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner 1 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62588 December 9th, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
251 East Anticham St, Hageshown, M. JUDITH MBAOUA, RA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b perState essaryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:25 AM Miguel Bomar Decembe 0 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months Days Hours Min. 80 Director July 10, 1928 090-32-8308 Argentina Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. Count 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Item "seles prime" in mast be nothered Washington 1 ☐ Yes 2 No Directo Mary land Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14507 High Rock Road 21719 United States Funeral 2 should be filed within 72 hours after death n and Mental Hygiene.

is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 <sup>1</sup>XYes 2□No *Specify:* Argentinean 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Broadcast U.S. Federal Government <del>Journalist</del> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon Rosenberg Rosa Povarchik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is many injury or other traumonce. Cheryl Bomar / Wife P.O. Box 949, Cascade, Maryland 21719 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date George Lown University December 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hospital 4 Donation 5 ☐ Other (Specify) 2008 Washington, D.C. 22. Name and Address of Facility Keeney and Basford PA Funeral Home, 21. Signature of Funeral Service Ligensee M01473 106 East Church Street, Frederick, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and in the cause). Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an rector, page 2 s autopsy perform 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death spital or Attending Pl tours after death. neral Director: After t' y filled in by the funera 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 6 To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D0063233 who completed cause of death (Item 23a) (Type, Print) 30 Name and andress of person who com Shahid Makmood 10 HAGERSTOWN, MO 21742

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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		•	For State Registrar	State of Ma	arylan	-			lealth a Death	ınd Me		giene Reg. No	Z H 113	3 4054
. K	Physici /Medic			mette-			l o				Date of Dea Month Dec .	Da 2	, 2008	3. Time of Death 12:16P M
	Examir	er	4a. Facility Name (If not institution, given washington Adversed S. Social Security Number 6.	ntist Hosp	ital	last birthday)	Ta	Town, or koma r 1 Year	Location of Park	C	Date of Birt	I	County of Dea	
	Funeral Director			1 □ M 2 🛛 F		73 Yrs.	Months		Hours	Min. J	B. Date of Birt (Month, Da une 24	y, Year) , 19	935 Nort	th Carolina  10d. Inside City Limits
	r 28a-f sho	irector	North Carolina Oran  10e. Street and Number	ge		Carrbo	oro   10f. Zi	p Code				10g. Cit	tizen of What Co	1 KTYes 2 □ No puntry?
	h with	a D	118 Glosson	Circle				2751	0				USA	A
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			Was Dece If Yes, spe 1  Yes		ispanic Orig in, Mexican, Specify:	jin? (Spec Puerto Ri	fy Yes or No- can, etc.)	-	14. Race - Ame Black, White Specify:	
21215-(	within 72 h jene. r than "natu the Medical	omplete	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5 2	5+)		dent's Usu kind of wo DO NOT u eache	ork done d se retired	ation during most b Aide	of warking	//	16b. K	ind of Business	•
Maryland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, It e IM.	To Be C	17. Father's Name (First, Middle, Las	t)	McNai	ir				's Name ( ⊇ggy	First, Middle,	Maiden	Surname) Winga	ate
Mar	12 shoth and 7 is m		19a. Informant's Name/Relationship  C. Freddie Burne			1	-				Route Numbe eek, M		or Town, State, . 20607	Zip Code)
	1 and Healt em 2		20a. Method of Disposition	tte (SOII)	20b. F	Place of Dispo	sition (Na	me of	1	Dat	· · · · · · · · · · · · · · · · · · ·		ocation - City or	Town. State
JO.	Pages nent of I ant: If ite		1 X Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		0	emetery, crei	matory or a	other plac	y 12	2/8/2			rrboro,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	5 TA	21. Signature of Funeral Service Lice						ss of Facility	001			al Servi	ice, Inc. 20011
	Physician /Medical Examiner	8	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each li aDue to (or as	ne. DIA	e A	RRY			cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
8760,	Attending Physician: The law requires that the death certificate be executed sr death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as	a conseq	uence of):	REY	PSI VAL	DIS	EASI	\$			~ 4 day
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P.O. Box	the death certifice by the attending ph Iched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2* No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	⊒ Ectopic   ⊒ Other (s		у				23d. Date of de Month	livery Day Yea <i>r</i>
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ita	stan: ertific ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death (	Check only o	<del></del>		
∑ V	Physic this ce al dire		1 ☐ Yes 2 💢 No			ER/Outpatie			4 🗆 1901				6 ☐ Other (Spe	ecify)
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	27. Manner of Death  1	oe lago of Ini	ury - At ho	28b. Time o Injury ome, farm, str	M		yat ?? Yes 2 □ N	lo	d. Describe h  f. Location (S  City or Tow	Street ar	nd Number or Ri	ural Route Number,
	ne Hospit: n 24 hours ne Funera pletely fille	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examina	owledge, deat ation and/or in	h occurred	d at the tir	ne, date and pinion, deat	d place, ar h occurred	nd due to the	cause(s date and	s) and manner a d place, and due	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	ayr					e number	3 74	4	29d. Da	ite signed (Mont	h, Day, Year) -08
R	8		30. Name and address of person who	completed cause of c	leath (Item	8 1+ A	Print)	(07	TAG	E C	174,	$\sim$	1D 20	722
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ars signa	Cart !								

within 2 To the I

Baltimore, Maryland 21215-0036

Box 68760

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Vital Records,

of

Division

31. Date filed (Month, Day, Year) State DEC 0 5 2008 Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D5895 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician SIE MARGARETE Nov 30 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rehab + Nursing Ctr.

| 6. Sex | 7. Age (In yrs. hest birthday) Dicomico Salisbury Social Security Number Salisbur If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 KF 45-12-4875 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No SALISBURY Director WICOMICO 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: way injury or other traumatic event, the Medical Examiner must be none. 21804 )SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔣 No Specify ģ 3 XWidowed 4 ☐ Divorced Maryland 21215-003 Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FCOD INDUSTRI 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) OTIGREENHILL CHURCH RD
of Disposition (Name of Date QUANTICO MD 21856
20c. Location - City of Town, State BETTY FRENCH SISTER IN LAW Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12-9-2008 SAUSBLAY, MID SPAINBHILL MEMORY CHADOK 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

43. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNETAL HOME POSOX GI BIVALVE, MED 21814 Immediate Cause (Final disease or condition resulting in death) Physician 22 1 00 par-/Medical Due to ( s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Leczo. Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for I in the past 12 months? Dav 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2☐NO 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 A Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မှ this Ö completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No e Hospital or Attendl 24 hours after death. e Funeral Director; A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) H. M.D. 2000 Ave, illiam 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 DEC 0 Refuse 4 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar 2008 **Physician** 10:08 p M Esther L. Beitler December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil Elkton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F 75 307-32-9752 Director December 4, 1932 IN Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2391 Old Field Point Rd. 21921 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: δ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 12 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John H. Clark Estalene Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Trent Rd., Elkton, MD 21921 Mark A. Beitler/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA R A Ferris Inc. December 6, 200k 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1∐Yes 2√DMo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No MI 1 □Yes MTN 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 Impatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred → Natural 5 🗌 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident after death Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) To the Hospital within 24 hours a To the Funeral C (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) comite hei 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION HOSPITAL NAMITA 31. Date filed (Month, Day, Year)
DEC 0,5 2008 32. Registrar's Signature State Registrar

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			1150 Madison  5. Social Security Number	St. Apt A		st birthday)	Anı If Under		olis   If Under	24 Hrs. 1	8 Date of Bir	A			indel ace (State o	r Foreian
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200	Physician	ai i	shock, or heart failure. List o	nly one cause on each lin	1,5	+x	10	1	Co	low				4	Onset and D	eath
	/Medical		disease or condition resulting in death)	a. ue to (or as a	conseque	ence of):		-4	CV		-				,,,,,	( .
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dealto (or as a	nonsequia	anne of):										
	executed an and rial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a conseque	ence of):										
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P.O. Box 6876	tificati g phy as the	Physician/Medica	-	u.											_	
ŏ	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			☐ Ectopic pr	eananc	:V			2	23d. Date		,	
Э.	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (sp		,				Mont	n	Day Y	'ear
	hat the	Phy	9 ☐ Unknown  Part II. Other significant condition	as contributing to death bu	itanot reault	tine in the u	nderlyina ca	use div	ren⊫in Part I		23e Did	tohacco u	se contrib	ute to th	e cause of de	eath?
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ME (ital)	an: T tificat tor, pa	a)	25. Was case referred to medical						26. Place	e of Death	1 □ Yes (Check only	2 No one)	1L	∃Yes	2 L No	
	nysich is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatie	nt 2 🗆 E	R/Outpatie	nt 3 🗆 DO	A Oth	or:		e 5 Res		⊙ □Other	(Specify	<i>(</i> )	
n of	ng Ph fter th nerai	T:U	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		28b. Time o	f 28	Bc. Injur Worl	ry at k?	28	d. Describe	how injury	y occurred	1		
Division	eath. or: A	Certification:	2 ☐ Accident investiga	ation			М	1 🗆	Yes 2□							
Σ	or Att	rţţ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry · At hon :. (Specify)	ne, farm, str	eet, factory,	office		28	3f. Location ( City or To	(Street and wn, State)	d Number )	or Rura	l Route Numi	ber,
	pital		29a. Certifier 1 Certifying	Physician: To the best of	of my know	ledge deat	h occurred	at the ti	me date a	nd place a	nd due to the	- Callee(s)	and man	ner as si	tated	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical		xaminer: On the basis of and manner sta	examination											}
	To the within To the complex	Me	29b. Signature and title of certifier	1 D A			29c	Licens	se number	( >	~	29d. Dat	e signed (	Month, l	Day, Year)	2
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	Stark	~	30. Name and address of person y	ho completed cause of de	eath (Item	23a) (Type,	Print	2		- 71	( , IF	10.	A	1401	c 26, ug Mni	defeat
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>29, 2008 **Physician** November 8:15pm м Alfred Bergmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** Months Days Hours Min. 1 1 M 2 □ F 149-03-9425 89 Director 08/02/1919 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show up or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Annapolis 1 ☐ Yes 2 🖔 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 787 Eastern Point Road 21401 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? I∏Yes 2 ☐ No 1 Ves 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1944<u>-</u> 1952 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Industrial Procurement Officer U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Bergmann Erna Feuerstein ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria R. Bergmann/Wife 787 Eastern Point Rd., Annapolis, MD 21401 permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr
once. 20b. Place of Disposition (Name of cometery, crematory or other place Lakemont Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 12/07/2008 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home ulle 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the denth. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dving, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Directo (or as a nonsequence of): If any, leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçeo use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown ieral Director: After this certificate has been sifiled in by the funeral director, page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 12 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 □No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 hours after deatl To the Funeral Director: completely the

Medical Certification: To 1 🛂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifles Name and advress of cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) DEC 0 2

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 5:19PM MILDRED FRANCES BURKETT December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN. 31, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. Director 194-26-7128 81 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Ħ r than "natural", or items 23a or 28a-f sh 1 ☐ Yes 2 ☐ No Director PENNSYLVANIA FRANKLIN GREENCASTLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14041 MERCERSBURG ROAD 17225 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u></u> Specify: 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN RICHARD MOATS MARY ELLEN PAYLOR traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau LLOYD S. YOUNKER, SON 358THURSTON LANE, FABER, VIRGINIA 22938 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STONE BRIDGE COB CEM. 12/8/2008 HANCOCK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furural Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, MD 21713 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heule myo cardia 48 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title a 00056379

Registrar

ddress of pers

who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ERNEST EUGENE BENNETT 2008 December 8. 12:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Whiteford Harford 1221 Old Pylesville Road

5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 □ F Yrs. Director 76 212-28-7691 11/5/1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🙀 No Director MD Harford Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Old Pylesville Road Funeral **USA** 21160 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
1 Yes, Give Year or Dates: 1958–60 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 → Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Parole and other than Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Probation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ပ္ Otto E. Bennett Emma Breedan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a Important: If item 27 is any injury or other trau once. Susan Bennett/Wife 1221 Old Pylesville Road, Whiteford, MD 21160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 12/8/2008 Leola, PA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval Between Onset and Death 23a Pari 1. Error the disease or complications that caused the death. If o not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cheece on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chrones obstructure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami Division of Vital Records, P.O. Box 68760(名 sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) n signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 00 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D32251 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air 21014 C. VAC Pho 31. Date filed (Month, Day, Year) State DEC 18 2008 Registrar

Pase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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DEC 1 8 2008

Be Completed by Funeral Director

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**Physician** /Medical

Examiner

Plea	ase Type or P	rint in Black Maryland / D					-			gible.			
For State Registrar	State of t	-	•	tificate of I		iiiu i	vieritai i iy	Reg. N	0	00/	9 4	175	5
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Social Security Number	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last birth		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D May 29	rth a <i>y, Yea</i>	35	1 1	thplace (St		eigi
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3 ₹ Widowed 4 □ Divorce	If Yes, Give Year or Date	s:	''	∐Yes 2 □XNo	Specify:				Spec	oify: Who	ite		
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7. Father's Name (First, Middle	· · ·						e (First, Middle 2 Wilcox		en Surna	ame)			
Andrew Sco		1	Merc	. A .d.d					+	- 0:::	7:- 0		
9a. Informant's Name/Relation Mrs. Bonnie Cl	, ,		-	Address (Street) Ast 8th S								)1	
Oa. Method of Disposition	lambers, III	20b. Place of I			rreet		Date PI				Town, Stat		_
Burial 2 Cremation		te cemetery	, crema	atory or other plac						•			
4 □ Donation 5 □ Other (		Aringi	_	National				!			Myer,	VA	
21. Signature of Funeral Service	Licensee	MO0255	106	Name and Address Seeney at East Cl	nd Bas	for St.	d PA Fi Frede	mer eric	al l	Home MD 21	L701		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, the conditions of the con	b	as a consequence of	g:	nyoc	and	`al	in	a	c th	P	ye Ye	and Death	
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2  Fetal death		Ectopic pregnancy Other (specify)	/					Date of de Month	livery Day	Year	
art II. Other significant condit	ions contributing to deat	h but not resulting in	the und	derlying cause give	en in Part I.		23e. Did	tobacco	use co	ontribute to	o the cause	of death	?
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7. Manner of Death	28a. Date of	Injury 28b. Ti	me of	28c. Injur		any m	28d. Describe				ony)		
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9a. Certifier	ng Physician: To the bell Examiner: On the bas	est of my knowledge,					, and due to the	e cause	(s) and			se(s)	_
one)	and manner	stated.											_
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31. Date filed (Month, Day, Year NFC 1 8 200	- B7.	istrar's Signatur	Se s										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** М CAMPBELL 11/29/2008 1656 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE
If Under 1 Year If Under 24 Hrs. SHADY GROVE HOSPITAL MONTGOMERY Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Director 1/31/1962 ST. LOUIS, MO 341-60-0866 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show event, the Medical Examinational be notified at 1√2 Yes 2 No Director GAITHERSBURG MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 8626 KELSO TERRACE 20877 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) COMPUTER ANALYST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHNNY CAMPBELL JANET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. STEPHANIE CAMPBELL/ WIFE 8626 KELSO TERRACE GAITHERSBURG, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/9/2008 CHELTENHAM, MD VETERANS CEMETERY 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses LANDOVER, MD 20785 7474 LANDOVER RD. 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARRYTHMIA /Medical Due to (or as a consequence of): **Examiner** MASSIVE GASTROINTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed METASTATIC COLON CANCER Due to (or as a consequence of): that initiated events resulting in death) Last attending physician for use as the buria P.O. Box 68760 Physician/Medical LIVER CIRRHOSIS 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 12 No 2 240 1 □Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0064478 11/30/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, MD 20850 FISEHATSION MEHARI 9901 MEDICAL CENTER DR.

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 5 2008

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan		artmen <i>tificat</i>			and M		giene Reg. No	200	R	40553
			Decedent's Name (First, Middle, L.)	.ast)							2. Date of De	ath	8.00 W L	3	. Time of Death
	Physicia		Diana B. C	ohn							Month Novembe	Da er 29	y Year 9, 2008		21:30P. <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, g		umber)		4b. City,	Town, or I	Location o				. County of Dea	ath	
, j			Laurel Hos	pital				aure1					rince G		
	Funeral			Sex 1□M 2¬F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Bi	rthplace o <i>untry)</i>	e (State or Foreign
	Director		220-38-3984 Usual Residence of Decedent	X	87	115.					Dec. 4	, 19	920   Per	nnsy	lvania
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d.	Inside City Limits
	Mary I-f sh	ţo	Maryland Prince	George	s Si	lver S	pring								Yes 2 No
	or 282	Directo	10e. Street and Number				10f. Zip					10g. Ci	tizen of What C	ountry?	?
	th wit	la L	3160 Gracefield	Road, #	1228			209					J. S. A	•	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atte event, the fredical Evantinar rust to rutified at	Funeral	11. Marital Status	Armed F		S. 13.	Nas Deced f Yes, spec	lent of His	spanic Ori n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		Indian,
30	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	l ∏Yes If Yes, G Year or	2∭ No Bive		1 ∐Yes	2 <b>X</b> No	Specify:				Specify:	Wh	nite
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7	y with giene rr tha	ĕ	Elementary/Secondary (0-12)	5-		Tea	cher					E	Education	on	
and	e filed al Hy I othe vent,	Be	17. Father's Name (First, Middle, La.	st)					18. Mothe	er's Name	(First, Middle	, Maider	n Surname)		
N N	2 should be and Menta Is marked aumatic ev	흔	Max Bellak						Ma	ry Ja	ane Lau	ter			
Mar	2 sho		19a. Informant's Name/Relationship				•						or Town, State,		
e '`	iges 1 and 2 should nt of Health and Mer If item 27 Is marke or other traumatic		Henry A. Cohn -	Son	100h F						aithers		g, Mary ocation - City o		
_	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3		n State	Place of Dispo emetery, cren			i				•		
altimo	# <b># # #</b> # .		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Na	tional					/2008				, Virginia
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+	cale be executed hysician and physician and physician and the britan-transit	Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Miju.) that initiated events resulting in death) Last	a	each line  Sopsis  o (or as a conseq  o (or as a conseq  o (or as a conseq	uence of): uence of):			, , , , , , , , , , , , , , , , , , , ,		. подряжить у			Int Or	pproximate erval Between nset and Death Hours
P.O. BOX 68/60	w requires that the death certificate be been signed by the attending physicis should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions	1 ☐ Live 4 ☐ Pre 9 ☐ Unl		l death 3 [ death 5 [	Ectopic p	pecify)			23a Did	tohacco	23d. Date of d Month use contribute	Da	
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	The larate has	Completed									24a. Was auto perfe		prior to death?	compl	findings available etion of cause of
VITal	cian: ertific ector,	Be (	25. Was case referred to medical examiner?					1011		of Death	(Check only	опе)			
on or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	tion: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Dat (Mo	n Inpatient 2 ☐ e of Injury onth, Day, Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 🗀 N		me 5 ☐ Res 28d. Describe		6 ☐ Other (Sp iry occurred	ecify)	
DIVISION	al or Atten s after deal I Director: ed in by the	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	ce of Injury - At he ding, etc. <i>(Speci</i> i	ome, farm, str (y)	eet, factory	, office			28f. Location ( City or To		nd Number or I e)	Rural Ro	oute Number,
	ne Hospit n 24 hours ne Funera	ledical (	29a. Certifier (Check only one)  1 ☐ Certifying 2 ☐ Medical Ex	aminer: On the	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date a pinion, dea	nd place, ath occur	and due to the red at the time	e cause( , date ar	s) and manner nd place, and di	as state ue to the	ed. e cause(s)
	To the vithing to the complete	Me	29b. Signature and little of dertifier	(),			29	c. License					ate signed (Moi		
b	70		) Cur	~	4			D240	)35			No	vember	30,	2008
			30. Name and address of person who Dr. Eugenio S.	Machad	lo	3110		field	l Rd.	Sil	ver Spi	ring	, Md. 2	090	4
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 4 2	008	Registrar's Signa	ture	we	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 9:33 2008 laroaret 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Maryland Medical Center Baltimore MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Davs 1 □ M 2 🖾 F Months April 04, 1934 New York 069-26-4443 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐Yes 2 🖾 No Maryland Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 U.S.A. 7426 Berryleaf Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 ▼ No 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2K No Specify: 3 x Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Composition Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin G. Carmody Helen Ritzinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Colleen Copeland - Daughter 909 Winhall Way, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Reinfoval from State 5 ☐ Other (Specify) Gate of Heaven Cemetery | 12/08/2008 4 ☐ Dopation Silver Spring, Maryland 22. Name and Address of Facility 21. Sign sure of Funeral Service Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) Pheumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery Month Day Year

Physician / /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

items 23a

6

"natural"

is marked other than

permit. Pages 1 and 2:
Department of Health a.
Important: If item 27 is
any injury or other trau

Examiner must be notified at

Director

Funeral

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Completed

To Be

the Maryland

with a or

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

ğ

Completed

Be

Certification: To

Medical

25. Was case referred to medical

1 Yes 2 No

examiner'

27. Manner of Death

1 Natural

2 Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

\*\*To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day	Year
Chronic Obs	sontributing to death but not resulting in the underlying cause given in Part I.  Twefive Pulmorary Disorder		o use contribute to the cause of 2 □ No 3 □ Probably 4 【	of death? Unkno
atrial fib	rill ation	24a. Was an autopsy performed? 1 □ Yes 2 ☑		gs availa if cause

	1 □ Yes 2 □	No 3□ Pro	bably	4 Unknown
	24a. Was an autopsy performed? 1 □Yes 2 ►No	24b. Were auto prior to co death? 1 □ Yes	mpletion	n of cause of
h (0	Check only one)			
me	e 5 ☐ Residence 6	☐Other (Speci	fy)	
280	d. Describe how injury	occurred		
28f	f. Location (Street and City or Town, State)	Number or Run	al Route	Number,
an	nd due to the cause(s)	and manner as	ctated	

	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Num City or Town, State)
Ì	29a. Certifier		clan: To the best of my knowledge, death occurred at the time, date and places. On the basis of examination and/or investigation, in my opinion, death occ	
l	(Check only one)	2∐ Medicai Examin	and manner stated.	surred at the time, date and place, and due to the cause(s

29b. Signature and title of certifier	MD

5 Pending investigation

1568598779

29c. License number

26. Place of Deat

Other: 4 \sum Nursing Ho

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

Samantha Wood MD 22 South Greene St Baltimore MD

31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

DEC 0 4 2008



1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

0

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 12 Physician 2008 9:09 P Jean Patricia Coughlan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) / 12/1917 9. Birthplace (State or Foreign Country) Newfoundland **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 91 578-46-0852 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 NNo MD Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 40 Moonshell Dr. or items 23a 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☐ Yes 2 📉 No Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: <u>چ</u> white 3 ☑ Widowed 4 ☐ Divorced 'natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Hair Salon Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Ellis n/a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Coughlan / son 40 Moonshell Dr., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 12/4/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GILDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Atter this certificate has been situated and all funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□**/√lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospital or Attending Ph 24 hours after death. Funeral Director: After th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the P within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

BA 5

State Registrar

12 103 12008

**ORIGINAL** 

EASTERN

SHORE DL, SALISBURY MD 21804

614

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 5, **Physician** Рм 2008 1527 Austin Clifford Chidester, Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, SEPT 7, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 11X M 2□ F Maryland 88 Director 222-07-3486 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or than "natural", or items 23a or 28a-f shovers. Wedical Examiner must be notified at 1 ☐ Yes 2 🛛 No Director North East Cecil Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 303 Old Zion Road 21901 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1939— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Myes 2 No 1939
If Yes, Give 1978
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 👿 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event " Elementary/Secondary (0-12) College (1-4or 5+) United States Army Career Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Austin C. Chidester, Sr. Lillian Jones ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6931 Tree Hill Road, Matthews, NC Mark S. Chidester/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20c. Location - City or Town, State December 9 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licenses 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician Due to (or as a consequence of): MINUTE disease or condition resulting in death) /Medical Examiner as a consequence of): 16 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Exami Due to (or as a consequence of): 5 YEARS 30 YEARS Physician/Medical ATHEROCCIEROSI IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

sician and burlaf-transit be executed Box 687607 physician at the burial use as signed by the attending I be detached for use as Ö ٦ Records, this certificate has been sail director, page 2 should of Vital funeral After Division death. spital or Attendil ours after death. neral Director; A

with the Maryland

death v

hours after

filed within 72 l

Baltimore, Maryland 21215-0036

show

Medical

within 24 hours a To the Funeral C 11/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

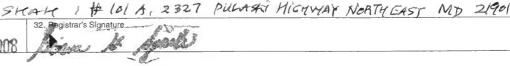
31. Date filed (Month; -Day, Year)

29b. Signature and title of certifier

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M.D

(Check only one)



DHMH 17 Rev 1/2001

Registrar

29c. License number

D0023334

29d. Date signed (Month, Day, Year)

9TH DECEMBER

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Edwin Milton Decker 80 0125 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death WMHS BRADDOCK CAMPUS **CUMBERLAND** ALLEGANY If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Year) 925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country MD Months Days Hours 1 □<sub>X</sub>M 2 □ F 219-14-6124 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Allegany Frostburg MD 1 ☐Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21532 One Kaylor Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Worker CSX Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Blair Decker Esther Mae (Root) Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 Grand Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Janet Light daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from State 12/15/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fur ranger of Licensee 22. Name and Address of Facility all Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease of combilidations, at used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate suse (Final disease or rondition resulting in leath) a. Due to-for as a consequence of: Approximate Interval Between Onset and Death wee Due to-(or as a consequence of) P515 Due to (or as a consequence of) potensia Due to (dr as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

event, the Medical Examiner must be nutified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner ment anne. Once.

Baltimore, Maryland 21215-0036

Directo

Completed by Funeral

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To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran certificate has be irector, page 2 s director, funeral After within 24 hours after death.

To the Funeral Director: #
completely filled in by the fu

Division of Vital Records, P.O. Box 68760, 🖔

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

8655

sville Maryland

Hecember 12, 2008

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State Registrar

130x265

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

Va

31. Date filed (Month, Day, Year)

		1 _ State	Department of Healt  Certificate of Deal	46	0000 1000
		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Deal	2. Date of Death	g. No. 2 0 0 3 4 0 3 3
Physic	an	Louise Patterson	Dean	Month December	Day Year
/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locati		r 12, 2008   2:40 ptff
Exami	ner	Record Street Home		_	Frederick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		der 24 Hrs. 8 Date of Birth	Birthplace (State or Foreign
Director		219-14-6068 1□M 215 97	Yrs. Months Days Hou	Min. Apr 7 Day,	911 Pennsylvania
		Usual Residence of Decedent			
arylan show			wn or Location ederick		10d. Inside City Limits
e Ma Ba-f s	cto	,			1 X Yes 2 □ No
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Experience roughly notified at	Funeral Director	10e. Street and Number 115 Record Street	10f. Zip Code 21701	10	g. Citizen of What Country? U.S.A.
ath w	ara	140 W 20 1 15 1 110		0:::0/0*	
er de	in.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mex</li> </ol>	c Origin? (Specify Yes of No- kican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give 3 🔀 Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2 X No Spe	cify:	Specify: White
Houn Italia			ia. Decedent's Usual Occupation	11	6b. Kind of Business/Industry
in 72	plet	(Specify only highest grade completed)	(Give kind of work done during i life. DO NOT use retired)		
I with giene	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Executive Directo	or	American Red Cross
othe other	Be C	17. Father's Name (First, Middle, Last)		other's Name (First, Middle, Ma	
yidilio 212 huld be filed withi Mental Hygiene. arked other than	일	Matthew McKinstry Patt	erson 1	Nell	Donnelly
Lal ylallo 2.12 2. should be filed within and Mental Hygiene. is marked other than aumatic event, tro Ma			9b. Mailing Address (Street and Nu		
C, M 1 and 2 Health em 27 i		Jane McClellan, Daughter	4813 Mount Zion	Road, Frederic	ck, Maryland 21703
permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tr once.		v cemei	of Disposition (Name of tery, crematory or other place)	1	0c. Location - City or Town, State
i i i i i i i i i i i i i i i i i i i		4 Donation 5 Other (Specify)	nsburg Crematory	Dec 13, 2008	Smithsburg, Maryland
partillor permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Livensey	22 Name and Address of Fa	irch Street. Fi	rederick, MD 21701
		Kolyn Kolsouse	Keeney & Bast	ford P.A. Fune	cal Home
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such	h as cardiac or respiratory arres	st, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	e heart fail	nre	Onset and Death
/Medical		resulting in death)  Due to (or as a consequence	0:	1	
Examiner	L	Sequentially list conditions.	structive pu	Immary di	Stase
p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):	/	
and and I-trans	Kam	that initiated events resulting in death) Last c. Due to (or as a consequence	l of		
rate be executed the burial-transit	一	bue to (or as a consequence	e oi).		
physi the b	dical	d			
o certif	sician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
eath atter for u	cian	23b. Was decedent pregnant in Live birth 2 Fetal dea   1 Live birth 2 Fetal dea   1 Live birth 2 Real dea   1 Live birth 2			Month Day Year
the d y the ched	ysi	1 ☐ Yes 2 X No 9 ☐ Unknown 9 ☐ Unknown	o El otilo: (oposity)		
that hed b deta	/ Phys	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in P	art I. 23e. Did toba	acco use contribute to the cause of death?
equires een sigr	d by			1 □ Yes	s 2 □ No 3 □ Probably 4 ☑ Unknown
w req	Completed			24a. Was an	24b. Were autopsy findings available
he la e has	l mc			autopsy perform	prior to completion of cause of ed?
In: T In: T Ifficat or, pa	ပ္ပ	25. Was case referred to medical	26 0	1 ☐ Yes 2 Place of Death (Check only one	Mo 1 □ Yes 2 No
sicia cert	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	041	Nursing Home 5 Resider	
~ s =		27. Manner of Death 28a. Date of Injury 28b	. Time of 28c. Injury at	28d. Describe hov	
Physer this eral di	٦	1 Matural 5 Pending (Month, Day, Year)			
nding Phy tth. :: After this e funeral di	ation:	Natural Sol rending	Injury Work? M 1 □Yes 2	2 □No	
Attending Phy ar death. ector: After this by the funeral di	ification:	2 Accident investigation	M 1 □Yes 2	28f. Location (Stre	eet and Number or Rural Route Number,
al or Attending Phy s after death. In Director: After this ad in by the funeral di	Certification: 7	2 Accident investigation 3 Suicide 6 Could not be	M 1 □Yes 2		
ospital or Attending Phy hours after death. uneral Director: After this ity filled in by the funeral di	Certification:	2 Accident 3 Suicide 4 Homicide  2 Accident 3 Coruld not be determined  28e. Place of Injury - At home, building, etc. (Specify)	M 1 □Yes 2 farm, street, factory, office	28f. Location (Street, City or Town,	State) use(s) and manner as stated.
the Hospital or Attending Phy in 24 hours after death. The Funeral Director: After this optietely filled in by the funeral di	edical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 □Yes 2 farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,	28f. Location (Str. City or Town, te and place, and due to the ca, death occurred at the time, da	State) use(s) and manner as stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: 1	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  2 Accident 6 Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)  28e. Place of Injury - At home, building, etc. (Specify)	M 1 □ Yes a farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,  29c. License numb	28f. Location (Streetly or Town,  te and place, and due to the ca, death occurred at the time, da	State)  use(s) and manner as stated. te and place, and due to the cause(s)  d. Date signed (Month, Day, Year)
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical Certification:	2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only one)  1   Certifying Physician: To the best of my knowled 2   Medical Examiner: On the basis of examination and manner stated.	farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,  29c. License numb	28f. Location (Streetly or Town,  te and place, and due to the ca, death occurred at the time, da	State) use(s) and manner as stated. te and place, and due to the cause(s)
	edical Certification:	2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of Certifier  30. Name and address of person who completed cause of death (Item 23a)	M 1 □ Yes a farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,  29c. License numb  D 0 5 5  a) (Type, Print)	28f. Location (Street, City or Town, City or Town, te and place, and due to the ca, death occurred at the time, day over 29	State)  use(s) and manner as stated. te and place, and due to the cause(s)  d. Date signed (Month, Day, Year)  December 12, 2008
V	Medical Certification:	2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a Aubrie J. Nagy, M.D., 300 West	farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,  29c. License numb  0055  a) (Type, Print)  Ninth Street, F1	28f. Location (Street, City or Town, City or Town, te and place, and due to the ca, death occurred at the time, day over 29	State)  use(s) and manner as stated. te and place, and due to the cause(s)  d. Date signed (Month, Day, Year)  December 12, 2008
V	Medical Certification:	2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of Certifier  30. Name and address of person who completed cause of death (Item 23a)	farm, street, factory, office  lige, death occurred at the time, dat and/or investigation, in my opinion,  29c. License numb  0055  a) (Type, Print)  Ninth Street, F1	28f. Location (Street, City or Town, City or Town, te and place, and due to the ca, death occurred at the time, day over 29	State)  use(s) and manner as stated. te and place, and due to the cause(s)  d. Date signed (Month, Day, Year)  December 12, 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. < . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hieu Van Dang December , l 2008 12:04 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F 586-10-2904 44 Yrs June 3, Vietnam 1964 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Welfall Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? with 3162 Fairland Road 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Technician Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lieu Dang Cham Do 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Judy Dang/Wife 3162 Fairland Road, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dec. Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring. MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pulmonary Embolism disease or condition resulting in death) 2 hours /Medical Due to (or as a consequence of) **Examiner** Cancer of the Liver 6 months Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed burial-tra 0.09289 resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending properties of Box IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate ! 1 ☐ Yes 2 3 No 1 Tyes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D26894 December 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 University Blvd. E., Silver Spring, MD 20901 Dang C. Bui, MD 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

DEC 04 2008

			For State of Maryland / Dep	artment of Health and Martificate of Death	, ,	ne No.2008	40561
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
П	Physicia		Mildred Geneva Detrow		Month 12	Day Year	9:50AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
н			Williamsport Nursing Home	Williamsport	7	Washingto	n County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign
L	Director		218–30–8627 1□ M 2¶F 86 Yrs.	Wildrand Days Florida	Sept. 5,	1922 Mar	yland
	pu .	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	aho	5	Maryland Washington County Hagersto				1 XYes 2 No
	the N	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	nuntry?
	a or	ក្	317 Antietam Dr.	21742		U.S.A.	one y
	eath	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp		14. Race - Ame	nican Indian.
	ter d	F	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
38	urs a	þ	Widowed 4 □ Divorced	1 ☐ Yes 2 ☐XNo Specify:		Specify: W	hite
Ö	filed within 72 hours after death with the Maryland Hybiene. ther than "natural", or itema 23a or 28a-f ahow int, the Madical Examinar must be notitied at	Completed		edent's Usual Occupation e kind of work done during most of work	161	b. Kind of Business/	Industry
2	hin 7	ed l	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	or th	Son	7 Cafe	eteria Worker	A	ircraft M	anufacturer
D	al Hy al Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	iden Sumame)	
<u>ya</u>	Ment Ment mrkac	2	Oscar McKinley Smith, Sr.	Nellie I	cene Stell	ler Smith	
Maryland 21215-0036	and and sum			ing Address (Street and Number or Run			Zip Code)
2	and ealth m 27			York Rd. Hagersto			
9	1 of H If ital		1 Aburial 2 Cremation 3 Hemoval from State	ematory or other place)		c. Location - City or	
Ē	ment ment: lury o		4 □Donation 5 □Other (Specify) Rose Hi				, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Be and the Transport of the Transport of the Than The Medical Examination of the Tolling at Once.		21. Signature of Funeral Service Licensee		_	-	neral Home
	20 = a	_	1) my my they	1331 Eastern Blvd.			
		Î	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart fallure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	•	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1			
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Division of Vital Records,	w requires that s been signed t should be det	d by	GI bleeding Immunoconic	Thrombacytopania	1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Ö	w req beer shou	Completed	3/	7. 7	24a. Was an	24h. Were au	utopsy findings available
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ā	in: T ificate or, pa	e C	25. Was case referred to medical	GC Diago of Door	-1	No 1 ☐ Yes	2 No
5	Attending Physician: It death. actor: After this certifice by the funeral director, i	00	examiner?  1   Yes   2   No		h <i>(Check only</i> on <i>e)</i> ome 5□ Residenc	on 6 DOther /See	out d
ō	Phys er this eral dii	7: To	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how		City)
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VIS.	Atter r dea actor	ffce	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office		et and Number or Ri	ural Route Number,
á	al or	ert	4 ☐ Homicide determined building, etc. (Specily)		City or Town, S	state)	
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funesal Director: After this certificate has completely filled in by the funeral director, page 2	alc	29a. Certifier 12 Certifying Physician: To the best of my knowledge, de				
	na Ho n 24 ne Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	
ķ			bralit lahmond	D00632	33	12/08/	2008
\ _2	71.7		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
2	H-6		580 Northern Ave Hagers	town MD	2174	2	
	Sta		31. Date filed (Month, Day, Year) 32. Resistrar's Signature	South :			
	Registr	ar	DEC 0 9 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year December 2, 2008 Elwood Robert Ev. Jr. 7:33 a 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year)
June 12, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Min. Months Days Hours 1 🖾 M 2 🗆 F 1941 Washington, 67 220-38-4528 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Maryland Maryland Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10709 Huntley Place 20902 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ★ Yes 2 No
If Yes, Give
Year or Dates: 1960-82 1 Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify: Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Security Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Elizabeth Fowler Elwood Robert Ey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Stevenson Ey/Wife 10709 Huntley Place, Silver Spring, MD 20902 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Dec. 3 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Due to (or as a consequence of): Basilar Artery Thrombus hours Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

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**Funeral** 

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Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The law requires that the death

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burial-transit and attending physician the as nse for been signed by the should be detached ate has bage 2 s certificate director, this funeral After t after death.

Examine Physician/Medical <u></u> Completed Be Certification: To

2 Accident 3 Suicide 4 Homicide

resulting in death) IF FEMALE 9 ☐ Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No 27. Manner of Death Natural

29a. Certifier

(Check only

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? I□Yes 2□No

yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 Unknown

28a Date of Injury

(Month, Day, Year)

3 Ectopic pregnancy 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of cort

5 Pending investigation

6 ☐ Could not be

29c. License number D64413 29d. Date signed (Month, Day, Year) December 2, 2008

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an

1 Yes

autopsy performed?

28d. Describe how injury occurred

2 **N**0

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

1 ☐ Yes

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Juanita L. Smith, MD

9901 Medical Center Drive, Rockville, MD 20850

State Registrar

filled in by

completely

Medical

within 24 hours a

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31. Date filed (Month, Day, Year) DEC 0 4 2008



**Physician** /Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 2 to the Funeral Director: After this certificate has been completely filed in both.

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e Funeral Difector: After this certificate has been signed by the eftending priystician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit	1
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown									of delivery h Day	Year		
Part 4 Other significant conditions PANCY TO PER	Na	seps	15,	erlying	cause given ir	Part I.				ute to the ca	use of death?		
respirator	79.	fallur	~_				24a. Wa au pe 1 ∐Yes	topsy rformed	pri de	ere autopsy for to complete ath?	indings available tion of cause of No		
25. Was case referred to medical					26	. Place of Dea	th (Check onl	y one)					
examiner? 1 ☐ Yes 2 █ No	Hospita	al: 1 Thipatient 2 🗆	ER/Outpatient	ome 5 □ Re	5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigat	288	a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work?	2 🗌 No			njury occurred				
3 ☐ Suicide 6 ☐ Could not determine		28e. Place of Injury - At nome, farm, street, factory, office							f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	aminer: C	: To the best of my kno on the basis of examina and manner stated.	owledge, death of ation and/or inve	occurre	d at the time, n, in my opini	date and place on, death occu	e, and due to t rred at the tim	the cause ne, date	e(s) and man and place, ar	ner as stated id due to the	1. cause(s)		
29b. Signature and title of certifier				29	c. License nu	mber		29d.	Date signed	Month, Day,	Year)		
MIN	Oe.	istan	ح		0000	416=	7		12/1	2/08	<i>`</i>		
30. Name and address of person when NOSHIW		LANT	MD 5	int)	Memo	rial f	lvenue	C	umber	land	MD 21500		
31 Date filed (Month, Day, Year)	-	32. Registrar's Signa	ature see a see	Total State of the last of the		•	-	1			-t		

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State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death December 10, 2008 **Physician** Eileen M. Ehst 7:40 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Tranquility of Fredericktowne Frederick 8. Date of Birth (Month, Day, NOV • 28, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Year 923 North Carolina Months Days Hours Min 1 □ M 2 □ F 85 069-24-4239 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, its Modical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21.703 6441 Jefferson Pike Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, It a Mo Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Louise Klos Stephen Kohout ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1311 Mulberry Court, Frederick, MD 21703 Mrs. Elaine C. Jachowski, Dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Smithsburg Crematory Dec. 11, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licence MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruss on each line. Approximate Interval Between Onset and Death aleu Immediate Cause (Final **Physician** en disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burlal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Syndow 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certificat 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Ashwal, M.D., 56 Thomas Johnson Dr., Frederick, MD 21702

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 8 2008

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10,2008 **Physician** NORMAN DAVID FLIGHT 8:19A DECEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Sep 5, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 578-60-4215 1 X M 2 □ F Scotland 69 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mant be notified at Frederick Frederick Maryland 1 ☐ Yes 2 🗷 🗙 o 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 9012 Mountainberry Circle Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Interior Decorating d 2 should be filed within 73 th and Mental Hygiene. 7 Is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Oriental Antiques/Art 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabella Flight Ford David ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. P.O. Box 1971, Frederick, Maryland 21702 D. Bauer Knight, P.R. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Dec 11,2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2Keener Ace Basford P.A. Funeral Home 21. Signature of Funeral Service Licensee M00706 106 East Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ATHEROSCLEROSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division of Vital Records, ≥ HYPERLIPIDEMIA HYPRRTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? DIVERTICALOSIS 24a. Was an cate has by page 2 s autopsy performed' 2 4No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 400 Certification; To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death ial or Attending Poster death.

al Director: After ted in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 8 21 9 3 6 29h. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DONIELSON MD 65C THOMAS THOMAS VOHNOW DR., FREDERICK, MD 2170Z

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If item 27 is marked other than "natural", or items 23a or 28a-f show in interest.

Physici /Medic Exami

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely stilled in but the transport directors. Re DHMH 17 Re

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mine		•	Northampton Manor Nursing Center							E		rederick		
ral tor		5. Social Security Number 213-24-9043 6. Sex 1 ☐ M 2 ☐ M		n yrs. last birth 87 Y		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth Apr o,	1921	9. Birt Mar	thplace (State or Foreign y Tand		
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C evening	lo be	17. Father's Name (First, Middle, Last)  James	I	Barnhou	ıse		18. Mothe		(First, Middle,	Maiden Suri	name) Boon	ie		
F traumar		19a. Informant's Name/Relationship (Type. Print) Mrs. Rebecca McKenzie,	Cousir			Address (Street a								
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ian cal		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. OVARIAN CANCEL												
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a in by me	Certification:	E LI Addition	et, factory, office											
erery illie	Medical	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and n		amination and										
	Me	29b. Signature and title of certifier	MO			29c. License number  21936			2	29d. Date si	th, Day, Year)			
+		30. Name and address of person who completed of A. DONEL SON, MD 66	ause of death	n (Item 23a) (	Type, Pr				DERIC	e,	nd :	21702		
State		31. Date filed (Month, Day, Year) 33.	. Registrar's	Signature	and i	J	-		-					
v 1/200		DECT 9 5000 Votes	9/1	5/										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10, Margaret Dec. 4:10 P Koerber Frey 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. 213-30-8623 9/20/1909 **Director** Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD. Baltimore Glen Arm 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 11630 Glen A rm Road 21057 United States Funeral 12. Was Decedent Ever în U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koerber Ernestine John Jacob Alma Abraham ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jocelyn F. St. Clair (Dau.) 1714 Gatehouse Court Bel Air, 21014 MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John Luth. Cem. 12/16/08 Long Green, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral delas Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AGRITIC **Physician** ANEURUSM DAYS dîsease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 \(\sumeq\) Yes 2 \(\beta\) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐Could not be 3 Suîcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, \$\sqrt{\sqrt{2}}\$ Division

altimore, Maryland 21215-0036

sician and burial-transit cate has been signed by the attending physician page 2 should be detached for use as the buria certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

29d. Date signed (Month, Day, Year) D64395 DECEMBER 11, 2008 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 6565 N LHARLES ST. 8WITE 209 BALTIMORE, MD 21204 DOBERMANIMO DANIENE 32. Registrar's Signature

and manner stated.

TO LAKE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

1

29a. Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month PHILLIP CHARLES FICKENS PM 2008 December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** A MATULANA Social Security Number Health Care If Under 1 Year (În yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F 250-42-0288 07/01/1930 **Director** SOUTH CAROLINA Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Event are must be mailthed at 1 Yes 2 No Directo MARYLAND **HARFORD** HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 232 SUPERIOR STREET 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ▼Yes 2 No If Yes, Give Maryland 21215-0036 1 □Yes 2 🕅 No Specify: BLACK ል 3 Widowed 4 Divorced Year or Dates: 1950-53 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SAW OPERATOR AVIATION PARTS MANFG. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES FICKENS LULA SNELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau NORMA FICKENS / SPOUSE 232 SUPERIOR STREET, HAVRE DE GRACE, MD 21078 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. JAMES UNITED CEM. 12/13/08 HAVRE DE GRACE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. Scott-Colomon 552 LEWIS STREET, HAVRE DE GRACE, MD 21078
of dying, such as cardiac or respiratory arrest,
of dying, such as cardiac or respiratory arrest,
onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ja Know N disease or condition resulting in death) Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) the attending physician a 68760 death certificate be Physician/Medical O. Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed Progressive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Supranuclear 24a. Was an page 2 s has autopsy performed?

1 □ Yes 2 ☒ No certificate of Vital this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

6 + IVA

Known to

Name

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Santas

DEC 0.5 2008

31. Date filed (Month, Day, Year)

151094-1

VA MARYland Health Care System, Perry Point, MD 21902 32. Registrar's Sighature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year  $\operatorname{\mathbb{P}}^M$ 2008 RICHARD GILLILAND December 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

11-5-1933 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Min. Wash. D.C. 75 578**-**42**-**8968 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show an "natural", or items 23a or 28a-f show well on Evaminer must be notified at MD Frederick Frederick 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5722 Sugar Maple Court **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KgYes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 9 3 ☐ Widowed 4 XBDivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene.

27 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Engineer Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Bryan Gilliland Sr Eva Demar မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau
once. Terresa A. Gilliland Daughter 4604 Mockingbird Ln Frederick, Maryland 21703 20a. Method of Disposition
1 □ Burial 2 💆 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12-13-2008 | Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Ser M01176 106 East Church St. Frederick, Maryland 21701 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANTENLY ATHERO Scienosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EMENTIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown After this certificate has been s funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer Yes 2 2 No 1 TYes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Funel completely file 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number IM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 Tall House Ave theoerick, MD 21701. SIBTE A KAZMI, HID 32. Registrar's signature 31. Date filed (Month, Day, Year) DEC 1 8 2008 State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1139 Ella M. Gibson Nov 2008 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ENINSULA REGIONAL MEDICAL CENTER Wicomica SALISBURY If Under 1 Year | If Under 2 If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗹 F Months Days Hours Min. 375-28-4166 76 Feb 15, 1932 Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Trinity Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ MNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ➡No Specify: Specify: Black 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Poultry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grady C. Stanford Mattie Belle Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Brown, Sr./son 618 Homer St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memory Gardens De 22. Name and Address of Facility Dec 6, 2008 Salisbury, MD 21. Signature of Funeral Service Licent ee Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Squeemos lung disease or condition resulting in death) De to (or as a consequence of Slastolle Dystunction ongestive Heet The betes reilitu Due to (or as a consequence of):

**Physician** /Medical Examiner

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page 2 certificate has

funeral director

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within 24 hours after deati To the Funeral Director:

**Physician** 

Examiner

**Funeral** 

Director

s 23a or 28a-f show

or Items

'natural",

7 is marked other traumatic event,

Department of Health a Important: If Item 27 is any injury or other tra once.

Pages 1 and 2 should be f nent of Health and Mental

event, the Medical Examinar

Director

Funeral

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Completed

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

68760,

Records,

Vital

of

Division

or Attending Physician:

/Medical

10a, State

MD

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and burial-trar physician

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

10burio 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Dav 5 Other (specify)

Physician/Medical Examiner þ Completed Be Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy

2 No

Year

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Natural
2 Accident 5 Pending investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifie

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

SAlisbury Md. 21801

performe

2 No

1 □ Yes

130067738

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

100 MD SABERI CARROLL

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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State of Maryland / Depa	artment of Health an	ıd Mental Hygiene	2000

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edic					-	4h. City. 1	2000.		c. County of Death								
min	er	4a. Facility Name (If not institution, give street and number)  Holy Cross Hospital							4b. City, Town, or Location of Death Silver Sprine					Montgomen			mery
ral tor		5. Social Security 577-28-		6. Sex 1 □ M		Age (In yrs.	. last birthda 85 Yrs.	y) If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Day, Y			irthplace Co <i>untry)</i> <b>ryla</b> ı	(State or Fore ad
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	ا <u>بر</u> ا	11. Marital Status	arried 2□ Marrie	A	rmed Force	es?		3. Was Deced If Yes, spec	ify Cubai	n, Mexica	n, Puerto	Rican, etc.)		Blac	ck, Wh	ite, etc.	
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	To Be		h Dennis		ingly							e R. C	_		ne)		
		19a. Informant's	Name/Relationsh	nip (Type. P	Print)		19b. Ma	iling Address	(Street a	and Numb	er or Rura	al Route Nu	nber, C	ity or Town,	State	, Zip Code	e)
		Kathy S	Shorter/1	Niece		23	302 Ch	apman	Road	i, Hy	atts	ville,	MD	2078	3		
		20a. Method of D	Disposition			20b.	Place of Dis	position (Nam	e of	0)		ate		c. Location -	City c	or Town, S	State
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State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) DEC 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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21215-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Yes, specify Cuba	n, Mexica Specify		.)	Specify:	hite, etc. Multirad	cial	
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	E 2' 4'		IF FEMALE:	23c. If yes, outcome	of pregnancy								10	
Box	The law requires that the death certifice has been signed by the attending to age 2 should be detached for use as	Physician/	23b. Was decedent pregnant in the past 12 months?		2 - Fetal death		Ectopic pregnancy Other (specify)				23d. Date of d Month	lelivery Day	Year	
P.O.	that the death ed by the atten detached for u	hys	1  Yes 2 No 9 Unknown	9 🗌 Unknown			care (opcomy)	-						
σ.	s that	by P	Part II. Other significant conditions	contributing to death b	out not resulting i	in the u	nderlying cause giv	en in Par	t I. 23e. I	Did tobacc	o use contribute	to the cause of	f death?	
ğ	w requires tha been signed should be de								·	f ☐ Yes	2 <b>Z</b> No 3□1	Probably 4 🗌	] Unknown	
ပ္တ	aw re	plet								Vas an lutopsy	24b. Were	autopsy findings o completion of	s available	
Division of Vital Records,	The late has page	Completed								erformed?	death?	?	cause of	
ita I	sician: The la certificate has irector, page 2	Be (	25. Was case referred to medical examiner?						e of Death (Check or	nly one)				
<u></u>	Attending Physician: The law sr death. ector: After this certificate has by the funeral director, page 2	၉	1 Ves 2 No	Hospital: 1 Inpatie		·		4 □ Ni	ursing Home 5 - F			ecify)		
5	iing P	ö	27. Manner of Death  12 Natural 5 Pending investigation	28a. Date of Inju (Month, Day		Time of njury	28c. Injury Work' M 1 □ Y	?		ibe how in	injury occurred			
/ISI	or Attending after death. Director: After I in by the fune	ficat	3 ☐ Suicide 6 ☐ Could not	be 28e Place of init	ury - At home, far	rm, stre		es 2 🗍		on (Street	and Number or	Rural Route Nu	mher	
á,	after Direct	Certification:	4 Homicide determined	building, etc	c. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
:	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the Funeral Director. After this director, completely filled in by the funeral director.		29a. Certifier (check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	fexamination and	, death d/or inv	occurred at the timestigation, in my op	e, date ar pinion, de	nd place, and due to ath occurred at the t	the cause ime, date a	(s) and manner and place, and d	as stated. lue to the cause	(s)	
1	vithin to the comp		29b. Signature and title of certifier				29c. License	_			ate signed (Mor			
	20		) IME				K	es (	$\infty$	12	210210	8		
_			30. Name and address of person who		leath (Item 23a)	(Type, F	Print)		600 North \	Nolfe:	St, Baltim	ore, MD,	21287	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4 20		r's Signature	free	E)							

			For State Registrar	Otate of Maryle	•	tificate of	Death	Reg. I	0000	10573
ı	Physicia	an	1. Decedent's Name (First, Middle, Last  Rose Fe		iser			Date of Death Month  Cecember	2, 2008	3. Time of Death 9:00PM
-mad-	/Medio		4a. Facility Name (If not institution, give	street and number)	20.72	-	r Location of Death	4	ac. County of Death	
and,			Genesis La Plata  5. Social Security Number 6. Se		rs. last birthday)	La P1a	T If Under 24 Hrs. Le	Date of Birth	Charle 9 Birth	1 (0)
ı	Funeral Director			<sup>2</sup> M 2 <b>2</b> F 95		Months Days	Hours Min. Sept	(Month, Day, Yea ember 21	,1913 Mas	place (State or Foreign ntry) sachusetts
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation			1	10d. Inside City Limits
	a-f sh	ctor	MD Charle	es	La	Plata				1XYes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code	0616	10g.	Citizen of What Cour	ntry?
	ms 23	neral	One Magnolia Dri	12. Was Decedent Ever in	n U.S. 13. \	1	0646 dispanic Origin? (Specifian, Mexican, Puerto Ric	y Yes or No-	USA 14. Race - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evarance must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	Armed Forces? 1		TYes, specify Cuba		can, etc.)	Black, White,	etc. white
15-(	n 72 h "natu edicel	olete	15. Decedent's Edu (Specify only highest grad	de completed)	16a. Deced (Give life, I	dent's Usual Occup kind of work done DO NOT use retired	oation during most of working d)	16b.	Kind of Business/In	dustry
212	filed withir Hygiene. other than	Som	Elementary/Secondary (0-12)	College (1-4or 5+)	_	ecretary			Insuranc	e
Baltimore, Maryland	2 should be file and Mental Hy is marked oth aumatic event	To Be (	17. Father's Name (First, Middle, Last)  Frank Fernandes				18. Mother's Name (F	First, Middle, Maid Silva	en Surname)	
Mar	nd 2 sho Ith and 27 is m		19a. Informant's Name/Relationship (7) Anne Liebrecht/da				and Number or Rural F <b>Drive , La</b>			Code)
nore,	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ f	Removal from State		sition (Name of natory or other place	tery 12/5/		Location - City or To	
altir	permit. Pages 1 Department of t Important: If ite any injury or of		4 □ Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens	NO OO			CHOLS FUNEI			
	<u> </u>		23a. Part 1. Enter the disease, or comp	lications that caused the d		211 St. M	ary's Ave.	La Plata		Approximate
	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Que to (or as a cons	cas f	21.7£1.0E	wice en		У	Interval Between Onset and Death
and a	Examiner	L	Sequentially list conditions.	b. 178 rbtr	NA				*	years)
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
, 0	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	icate b physic s the br	Medical	•	d						
O. Box	ath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 [	Ectopic pregnand Other (specify)	у		23d. Date of deliv Month	ery Day Year
S, D	es that the de igned by the a	by Ph	Part II. Other significant conditions co	entributing to death but not	resulting in the un	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ord	w require s been się should b		-				_		2KNo 3□ Pro	bably 4 Unknown
of Vital Records,	: The law cate has b page 2 s	Completed			<u>.                                    </u>			24a. Was an autopsy performed 1 ☐ Yes 2 🖺	prior to co	opsy findings available ompletion of cause of
ita	sician: The certificate irector, pag	Be Cc	25. Was case referred to medical examiner?		-		26. Place of Death (0		No 1 □Yes	2 ∐ No
of V	Physic this ceral dire	2	1 ☐ Yes 2 ♣No		2 ER/Outpatier		4 Lanursing Home	5 Residence	6 Other (Speci	fy)
ion	ing Afte une	ation	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea.	r) Injury	Wor	k?  Yes 2□No	a. Describe now in	ijury occurred	
Division	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	at home, farm, str ecify)	eet, factory, office	28f	Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	e Hospital n 24 hours a e Funeral l	Medical (	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	/sician: To the best of my iner: On the basis of exan and manner stated.	knowledge, death nination and/or in	h occurred at the ti vestigation, in my o	me, date and place, an opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	, Me	29b. Signature and title of certifier	holl	nn	29c. Licens	se number	G 29d.	Date signed (Month,	Pay, Year)
	85		30. Name and address of person who c	completed cause of death (	Item 23a) (Type,	Print)	NAN	DRE	MQ 2	2010
	Sta		31. Date filed (Month, Day, Year) DEC 0 4	32. Registrar's Si 2008	a	1 40	V-12012	V \ - \ /		V-V-
DU	Registr	001	VLV V 4	LOOK MEDICAL	10 /6	parks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14, ZCC8 **Physician** Thomas Greenleaf November /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner アナカカイ 1-1-27 ISVIV mg BWMC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 21 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **1**℃ M 2□ F Feb 1946 Maryland 62 212-44-7617 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10a, State 1 ☐ Yes 2√2 No Directo Maryland Anne Arundel Gambrills 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 1710 Bargers Rd. 21054 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2√☐No Specify: Specify: Q. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Charles Co. Dept. Elementary/Secondary (0-12) College (1-4or 5+) 12th Social Worker Social Services 6yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Greenleaf Rosie Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Traci Frederick(Daughter) 1209 Winchester St. Baltimore, Md. 21217 20c. Location - City or Town, State 20a. Method of Disposition 20b Which of Disposition (Name of 1 a 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 11-29-08 Gambrills, Md. 4 Donation 5 DOther (Specify) Winname Reverse of SaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. Larry S Beese MOS 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate I 1 ☐ Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ npatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2412008

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 30 1 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician LINDA GRUSE 01:23 PM DECEMBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 18,1944
Sept. 18,1944
England Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Days Hours 356-34-9774 64 Sept. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f shov notified at Director Maryland Washington County Hagerstown 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 pe ral", or items 23a Examiner must b 14035 Sweet Vale Drive 21742 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Year or Dates "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ... withill marked hygiene. 27 is marked other than "v traumatic even". Elementary/Secondary (0-12) College (1-4 or 5+) 4 Anatomic Pathology Supervisor Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Charles Woolcox Dorothea Howells Woolcox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 671 S.E. Prineville St. Port St. Lucie, FL 34983 Cheryl Ann Fleig-cousin Department of Health Important: If Item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 🔏 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12-8-2008 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home aittin )a 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) METHSTATIC GASTRIC ADEMOCARCINOMA YEARS \/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examir physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 

Ectopic pregnancy for in the past 12 months? Month Year Dav signed by the att 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 ☐ No 3 ☐ Probably 4XQUnknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? has certificate 2 XNo 1 ☐ Yes 2 ☐ No ours after death.

ours after death.

filled in by the funeral director, i 25. Was case referred to medical Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐No ၉ 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

31. Date filed (Month, Day, Year) 2008 9 DEC 0

(check only one)

29b. Signature and title of certifie



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

P21617,

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DECEMBER 5, 2008

Registrar

		1 - For State Registrar	State of Maryland / [		rtment of He			iene 2 (	008 4:0576
Physic	ian	Decedent's Name (First, Middle, Last)	ARIE	G	RANT		2. Date of Deat	h	2 Year 13.03 M
/Medi Exami	cal	4a. Facility Name (If not institution, give stre	<u> </u>		4b. City, Town, or L	ocation of Death	DECEMBE	4c. County	- 000
	M	The Johns Hopkins Hos  5. Social Security Number 6. Sex	pital  7. Age (In yrs. last bir	thdav)	Baltimore (	City If Under 24 Hrs.	8. Date of Birth	Non	9. Birthplace (State or Foreign
Funeral Director			37	Yrs.	Months Days	Hours Min.	6-26-19	34	Country) Costerhout
aryland show		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Loc	cation				10d. Inside City Limits
e Mary 8a-f sh tified a	ector	MD Howard	Columb	ia					1 ☐ Yes 2 🔀 No
death with the Maryland ms 23a or 28a-f show must be notified at	I Dir	10e. Street and Number 6336 Cedar Lane			10f. Zip-Code 21044			0g. Citizen of V USA	What Country?
	Funeral Director	TT Maria Olalas	Was Decedent Ever in U.S. Armed Forces?	13. V	L Vas Decedent of His i Yes, specify Cuban	panic Origin? (Si , Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
ING 21215-UU36 be filed within 72 hours after tal Hygiene. d other than "natural", or ite event, the Medical Examine	þ	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specif	y: White
1 5-UU36 72 hours aff "natural", or dical Exami	Completed	15. Decedent's Educa (Specify onfy highest grade c	completed)	(Give I	ent's Usual Occupa kind of work done di OO NOT use retired)		king	16b. Kind of B	Business/Industry
Z 1 Z Z vithir d withir giene. r than the Me	d mo	Elementary/Secondary (0-12)	College (1-4 or 5+)		istered N	urse		Nursi	ng
Viand  July be file  Mental Hyg  arked othe  attc event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
Marylan d 2 should be th and Mental traumatic ev	၉	Henricus Gijsber 19a. Informant's Name/Relationship (Type.		o. Mailin	g Address (Street a		aria Adr ural Route Numbe		
≥ 5 € 2 £		Bruce Grant/ Step-So			Darling	ton Rd.,			
MOFE, Pages 1 ar		20a. Method of Disposition  1 ☐ Burial ★★Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State cemete	ery, crem	sition (Name of natory or other place rematory			Hanove	- City or Town, State
<b>EXALTIMOTE,</b> permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of uneral Service Livensee	M01411	22	. Name and Address	s of FacilityHar	ry H. Wi	tzke's	Family F.H.
T		23a. Part 1. Enter the disease, or complica	tions that caused the death. Do				<u> </u>		City, MD 21043  Approximate Interval Between
Physician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition	DUDTURE	1) 7	HORACU	a ANE	URYSM		Interval Between Onset and Death
/Medical 'Examiner	ı	resulting in death)	Die to (or as a consequence				,		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	Oi).					
ecuted and II-transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
X 68 / 6U, certificate be executed ding physician and use as the burial-transit	dical	d.,			···				
ertificat ling physe as the		IF FEMALE:	:. If yes, outcome of pregnancy					and Do	to of delivery
H.C. BOX 68 that the death certific do by the attending placed for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)				ite of delivery onth Day Year
requires that the death een signed by the attenthould be detached for its could be detached for its country.	, Phy	9 Unknown Part II. Other significant conditions contri		in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use con	tribute to the cause of death?
N S E S	ed by						1 □ Y€	es 2 No	3 Probably 4 Unknown
> 0 w	Completed						24a. Was ar autops perforr	iv l	Were autopsy findings available prior to completion of cause of death?
VICAL ING sician: The la certificate has lirector, page 2		25. Was case referred to medical				26. Place of Dea		2 No	1 Yes 2 No
Of VICE Physician: this certificated director,	To Be		spital: 1 Inpatient 2 ER/Ou	•	3 DOA Other	r: 4 ☐ Nursing H	ome 5 Reside	ence 6 🗆 Oth	
On C	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of Injury	Work?	at Pes 2 ∐ No	28d. Describe ho	ow injury occur	rred
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (St City or Town		ber or Rural Route Number,
spital o ours af ours af ieral Di			ian: To the best of my knowledge						
the Hos in 24 h the Fur npletely	Medical	one)	r: On the basis of examination an and manner stated.	nd/or inv					
	2	29b. Signature and title of certifier	PMD		29c. License	532		9d. Date signe YEEMS	d (Month, Day, Year)
SEG		30. Name and address of person who com	pleted cause of death (Item 23a)	(Туре,					
	ate	31. Date filed (Month, Day, Year)	SUBBARTO 32. Registrar's Signature	M	)	600	North Wol	fe St, Ba	Iltimore, MD, 21287
Regis		DEC 0 4 200		1	rester				

08-09088 Juan D. Gomez

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 40577

Physician (a) Examiner  In Decement Name (First, Middle, Last)    Decement Name (First, Middle, Last)   Decement State   Dece			For State				Cer	tificate	of i	Death					eg. No.		Ta	. Time of Death
The control of the co		n/ 1	. Decedent's Name		lle,Last)	0707	Juan	Gomes						. Date of Dea Month Decembe	Day 20			
Service Search your purpose   Comment   Commen	Olcal Examin	4	la. Facility Name (i	f not institution	on, give stree	t and number	er)		41			ocation of			N	/lontgom	ery	
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Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

or Attending Physician: after death within 24 hours a

To the Funeral I

completely filled Hospital

10 State Registrar

Name and address of who completed car 31. Date filed (Month, Day, Year)

and manner stated

29c. Nicense number

29d. Date signed (Month. Dav. Year)

32. Registrar's Sig

DEC 0 5 2008

29b. Signature and title of certified

29a. Certifier

(Check only one)

📹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			For State Registrar	State of Ma	iryland /		rtificate of i			ene / eg. No. <	2008	40	579
	Physicia	n	1. Decedent's Name (First, Middle, Las						2. Date of Deatl Month	Day	Year	3. Time of	
	/Medic	al		gina Caput	o Hami	1ton		Location of Death	Decembe		ounfy of Death	0630	A M
	Examin	er	4a. Facility Name (If not institution, give Union Hospital	street and number)			E1kton				Cecil		
<u></u>	Funeral		5. Social Security Number 6. Se		(In yrs. last I	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State o	r Foreign
	Director		192-24-7934	□M 2 <b>X</b> 1F 7	7	Yrs.	Widitiis Days	Tiours Will.	April 9,	193		sylvar	nia
	land Dw It		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside Ci	ty Limits
	Mary I-f sho fled a	ţo	Maryland Cecil		E1ki	ton						1 ☐ Yes	2 📉 No
	or 28a e noti	Funeral Director	10e. Street and Number				10f. Zip Code		10	Og. Citize	en of What Cour	try?	
	23a c ust b	ral	60 Hamilton Lane				21921				ited Sta		
	tems	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Americ Black, White,</li> </ol>		
36	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	40	1	1 □ Yes 2 🙀 No	Specify:		S	Specify: Whi	te	
Maryland 21215-0036	2 hou latura ical E	ted	15. Decedent's Ed (Specify only highest gra	ucation	16		dent's Usual Occup	ation during most of work	ring	16b. Kind	d of Business/Ind		
215	thin 7 ie. ian "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT use retired	d) -	ang		utomobi]		
21	led wi lygier her th ht, the	Co	12 17. Father's Name ( <i>First, Middle, Last</i> )	-		Cor	nputer Op		e (First, Middle, N		anufactı	ıring	
ano	d be fi	) Be	Ralph Caputo						a Fiorot	naideii 6	diname,		
3	shoule nd Me mark matie	욘	19a. Informant's Name/Relationship (7	ype. Print)	1	9b. Mailin	ng Address (Street	and Number or Ru		City or	Town, State, Zip	Code)	
M	and 2 alth a 27 is		Clifton H. Hamilto	n/Husband	F	0.0.	Box 587,	Elkton,	MD 2192	2			
ore,	of He of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. Place ceme	of Dispo	sition (Name of matory or other plac	Decei	nber :	20c. Loca	ation - City or To	wn, State	
altimore,	Pagiment ment lant; I		4 □ Donation 5 □ Other (Specify	)	R. A.	Ferr	is & Co., I	nc. 10.	2008	We	st Ches	cer, P	A
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licen	see		H:	Name and Addre	ss of Facility for Fund ockton St	erals, P	Α.	MD 01	001	
			23a. Part1. Enter the disease, or comp	olications that caused	the death. D	o not ent	er man mode of dyir	ng, such as cardiac	or respiratory arre	est,	, MD 21	Approximate Interval Bet	e
	Physician	gs - 0	shock, or heart failure. List only immediate Cause (Final	one cause on each lin	10.	2	tre	()	nce.			Onset and I	ween Death
2	/Medical		disease or condition resulting in death)	a. Du to (or as	a consequenc	e of):	~ · ·	0.0.	, ,				
	Examiner		Sequentially list conditions	b. 'Se	05	15	,						
0	Sit 60	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):							
عرر	and and II-tran	Examine	that initiated events resulting in death) Last	cDue to (or as	a consequenc	e of):		· · · · · · · · · · · · · · · · · · ·					
68760,	ficate be executed physician and is the burial-transit	ia E		d									
		ledical	-										
Box	death certifi e attending od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 DLive birth		ath 3⊑	∃Ectopic pregnanc	y		23	3d. Date of delive	,	Year
	ne dea the at hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5□	Other (specify) _				WOTH	Day	Todi
P.0	w requires that the d been sign <b>e</b> d by the should be detached		Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco us	e contribute to the	ne cause of c	death?
or Vital Records,	quires n sign uld be	d by							1 □ Ye	s 2	] No 3 ☐ Prob	ably 4	Unknown
000	law reas bee	Completed							24a. Was ar		24b. Were auto	psy findings mpletion of c	
Ä	0 5 0	mo							perforr	ned?	death? 1 ☐ Yes	No No	au36 01
/ita	yslcian: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	Hospital: 4			011		th (Check only on	e)			_
or	di S	-T	1 Yes 2 No  27. Manner of Death	Hospital: 1. Inpatie	nt 2 ER/	Outpatier		4 LI Nursing H	ome 5 Reside			y)	
	ding h. After funer	tion	17 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	Wor	k? Yes 2∐No	200. 20001120 110	, injury	occurred		
Division	Attending r death. ector; After by the fune	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ury - At home,	farm, str	eet, factory, office		28f. Location (St City or Town		Number or Rura	al Route Nun	nber,
ă	tal or rs affe al Dir ed in l	Certification:	4	building, ea					City of 10wi	r, Glale)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ysician: To the best on niner: On the basis of and manner sta	f examination								s)
	To the within 2 To the Complete	Mec	29b. Signatore and title of certifler	and manner ste			29c. Licens	se number	2	9d. Date	signed (Month,	Day, Year)	
	F > F 0		Colon		-	M	DDD	0564	19	12/	10/05	3	
	10		. Name and address of person who	completed cause of d	eath (Item 23	a) (Type	Print		not	11/	// /% *	9/00	,
	10	1	Gloria Simor		> // V	v. H	igh St.	Duite.	226	Kta	nMM) a	(172	1
	Sta Registi		31. Date filed (Month, Day, Year)	oz. Hegistr	ar's Signature	Spell	5						
			DEC 1 8 2008	Jan War	per fr	Charles And							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11/29/2008 WILLIE HUNT 1345 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1 M 2 □ F 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 227-34-8000 81 NORTH CAROLINA Director 1/15/1927 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No MD MONTOGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 10000 BRUNSWICK AVE #419 20910 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 10 1 ☐ Yes 2 🔀 No Specify ģ 3 Widowed 4 Divorced "natural", BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 3RD COOK HELPER GOVERNMENT permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, Ih 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN HUNT SARAH ပ္ HINTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IDA HUNT/WIFE 10000 BRUNSWICK AVE #419 SILVER SPRING, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 12/8/2008 RIVERDALE, MD 5 ☐ Other (Specify) RIVERDALE CREMATORY 4 Donation 21. Signature of Funeral Service Livensee 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME WASHINGTON, DC 20011 716 KENNEDY ST. NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Userny g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE nse : 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) P.0. □Yes 2□No the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ENDSTAGE RENAL DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CARDIOMYOPATHY page 2 autopsy performe certificate 2 **X** No 2 □ No Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. Il Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Homicide 24 hours 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Patel Jayonti 30/08 10052586

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huly (2011 Huspita

31. Date filed (Month, Day, Year)

DEC 0 5 2008

1500 FOREST GLEN RD.

SILVER, SPRING,

			For	artment of Health and Mertificate of Death	ental Hygien Reg. N	_
	7 7 40	\$\bar{\pi}{\pi}	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		GARY PHILLIP HERRING	I	Month D.  DECEMBER 2	• 2008 4:40 P
V.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
Ć.			5509 SANJUAN DRIVE	CLINTON		RINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birthplace (State or Foreign Country)
	Director		215-66-8221		OCT 7 19	53 VIRGINIA
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation		10d. Inside City Limits
	Maryi f sho led a	tor	MD PRINCE GEORGE'S CLINTO	ΝΤ		1 ☐Yes 2 ☐ No
	the 28a- notif	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	3a or	O IE	5509 SANJUAN DRIVE	20735		USA
	r 72 hours after death with the Marylar "natural", or items 23a or 28a-f show polical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Miss Decedest of Illian sale Octobe (October 1997)	cify Yes or No-	14. Race - American Indian, Black, White, etc.
စ္	after or ite mine		1 Never Married 2 Married 1 1 Yes 2 No VIETNAM—	1 ☐ Yes 2 No Specify:	, mouri, otory	
8	ours Iral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: —ERA	A		OBA
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vither than "hatural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ng   16b.	Kind of Business/Industry
12	withir ene. than he Me	шc	Elementary/Secondary (0-12) College (1-4or 5+)	RUCK DRIVER		DDTTAME
	filed Hygi ther	ပို	17. Father's Name ( <i>First, Middle, Last</i> )		(First, Middle, Maide	PRIVATE an Surname)
an	id be ental ked c	To Be	JOHNNIE J. HERRING	BETTY	JO LOVIN	GOOD
Maryland	shou ind M ind M imar	Н	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ling Address (Street and Number or Rura		
	and 2 alth a alth a 27 is		BETTY JO HERRING/MOTHER 7900	JOHNSON AVENUE LAN	JHAM MARYL	AND 207.06
re	of He of He litem		20a Method of Disposition   20b. Place of Dis	position (Name of Dematory or other place)	Date 20c.	Location - City or Town, State
<u>Ĕ</u>	Pages nent of I ant: If its ury or o		4 Donation 5 Other (Specify) MD VETE	RANS CEMETERY 12/12		ELTENHAM, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Lip inser	22. Name and Address of Facility $$ J $_{ extstyle .}$		NS FUNERAL HOME
	D. D = 60		23a. Part1. Enter the disease, or complications that caused the death. Do not e			Approximate
	e		shock, or heart failure. List only one cause on each line.		respiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  OBSTRUCTIVE SLEE  Due to (or as a consequence of):	P APNEA		
	Examiner		MORBID OBESITY			
		Jer	Sequentially list conditions D.			
	od d ansit	Examiner	cause. Enter Underlying Cause (bisease or injury that initiated events c			
o,	an an rial-tr	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	dical	d			
Ф	ertifica ing ph e as t	Med	IF FEMALE:			
Box	ath ce ttendi or use	ian/	23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome pr pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
о <u>.</u>	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		
<u>α</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ds,	signe d be	d by	CHRONIC OBSTRUCTIVE PULMONARY DISEAS	SE	1 ☐ Yes	2 No 3 Probably 4XXUnknown
Ö	v requii been s should	etec			24a. Was an	24b. Were autopsy findings available
or Vital Record	he lav e has ge 2 :	Completed	HYPERTENSION	+=- · ·	autopsy performed?	prior to completion of cause of death?
ta	iclan: Th certificate ector, pag	e Co	RENAL INSUFFICIENCY 25. Was case referred to medical	26. Place of Death	1 Yes 2 X	No 1 ☐ Yes 2€ No
>	Physician: r this certificaral director,	o B	examiner? 1 → Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	1	37	6 □Other (Specify)
0	ding Physician: The n. After this certificate hr funeral director, page	<b>-</b>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	28d. Describe how inj	
0	Attending Prdeath. ector: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	or Attendafter death Director:	tifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a	and Number or Rural Route Number, ate)
	ital or irs afte ral Di	Certification:				
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier (Check only one)  1			
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	F & F 00		Dame 6 Hem. Inh	MD# 0101233709		EMBER 3, 2008
,^	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		
K			DANIEL E. HERMAN, M.D., VAMC, 50 IRV		INGTON, DC	20422/688
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	ar	31. Date filed (Month, Day, Year)  DEC 0 5 2008  32. Registrar's Signature	<b>7</b>		
	10.011.4					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Lsoac Itolland 26 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6300 Arrowhead 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) Sex. 1 M M 2 □ F Days 219 56 8424 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21643 rive 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 1979 1 Ves, Give Year or Dates: 0 7 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manutacturing Assembly 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAGC 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Acrowhead DPOUSE MD 10cK aroll Method of Disposition 1 Burial 2 Cremation Date 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) 8 ZUX HURLOCK Funeral Itume, 21. Signature of Funeral Service Licenses 510 21613 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancer a consequence of) Due to (or as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21/No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ☐ No 24a. Was an autopsy performed Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Is marked other traumatic event,

permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any injury or other trau

Funeral Director

Be Completed by

ပ္

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Pages 1 and 2 should

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division or Vital Records,

physician and is the burial-trans attending p as signed by the a s certificate has the lirector, page 2 s director,

The law requires that the death certificate be executed To the Hospital or Attending Physician: this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 12 Natural 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

bK State Registrar

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Signature

(accol)

2008

31. Date filed (Month, Day, Year

John Peter Hall,	lr.	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
John Feter Hall,		1- For State Cortificate of Dooth	4058
Physicia		Registrar Reg. No.	e of Death
Medical Examin		Month Day Year	09 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
		Holy Cross Hospital Silver Spring Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace	(State or
Director		215-88-6945	D.C.
	ŀ	Usual Residence of Decedent	
any	١		nside City Limits
nd Show	_	Maryland Montgomery Wheaton	Yes 2 XNo
W sar	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
the M	盲	2906 Blue Ridge Avenue 20902 USA	
5333 ceath with the Maxyland or items 23a or 28a-f show must be notified at once.	힐	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Ind	ian, Black,
death death	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
age	Ð.		
ours.			,
6 172 h	ě	Elementary/Secondary (0-12) College (1-4 or 5+)	.
003 within iene.	Completed	Painter & Paper Hanger Home Improver	ment
filed Hyg d oth			
12 Id be fental	Be		ode)
Baltimore, MD 21215-0036  Baptimore and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	입	John Peter Hall, Sr./Father 2906 Blue Ridge Avenue, Wheaton, MD 209	
and 2 ealth em 2 rraun	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	
Ore of H		1 Burial 2 XCremation 3 Removal from State crematory or other place)  Dec. 16	
timent trants		4 Donation 5 Other Specify: Metropolitan Crematory 2008 Alexandria.	Virginia
Salt Separi minon		21. Sgnature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc.	
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	MD 20902
Physician /Medical	М	failure. List only one cause on each line.	ween Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Propoxyphene intoxication  Due to (or as a consequence of):	Death
1		b	
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause   Company   Co	
nsit led	Exa	events resulting in death) Last Due to (or as a consequence of):	
executed ian and ial - transit	ical	XUNPENDED	·
30, te be o	ledi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici luneral director, page 2 should be detached for use as the buri	cian/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 25b. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 23d. Date of delivery Month Day	Year
x 6 th cer trendi	icia	past 12 months?  Pregnant at time of death  Other (Specify)	
Box e death c the atten ed for us	Physi	1 Yes 2 No 9 Unknown 9 Unknown	
hat th	by P		
S, P.  Lires th  signe d be de	be	1 Yes 2 V No 3 Probably 4	
of Vital Records, ig Physician: The law requir nor this certificate has been s neral director, page 2 should	Completed	24a. Was an 24b. Were autopsy find to complet	
ec he lav	E	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
m: T			
Vita ysicii his ce	o Be	No. 1 Ves 2 No. 1 Inpatient 2 V ER/Outpatient 3 DOA 1 1 4 Nursing Home 5 Residence 6 Other:	
of vig Ph	$\vdash$	27 Manner of Death 128a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
on sath or: △	흥	Natural 5 Pending Fd 12/12/08 FD 6:00 am 1 Yes 2 X No unk	
Division falor Attendi rs after death at Director: /	Ę	2 Accident Investigation   FO 12/12/10   FD 5:00 alpt   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rural Round Street and Number or Rural Round Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Street   10/2/25   Frederick Str	ite Number, City
Division of Vipital or Attending Phours after death reral Director: After titled in by the funeral	Certification:	house black Could not be determined (Specify) house from State 10225 Frede	erick Ave
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bun			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	e(s)
E > E 8	Re	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da)	y, Year)
		O.C.M.E. December 14, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	
	5 N	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St	ate	te 31. Date filed (Nouth DatyYear) 2008 37 Registrar's Signature	
Regist	trar	DEO TO COOL DESIGNATION OF PARTY.	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gladys Heald November  $p^M$ 27, 2008 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Sept. 01, Director 302-05-2608 91 1917 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maricel Examiner mast be notified as any injury or other traumatic event, the Maricel Examiner mast be notified as any injury or other traumatic event, the Maricel Examiner mast be notified as agree. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5550 Tuckerman Lane #454 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Toliver ဂ္ Jache Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roger Heald / Son 20616 Dubois Court; Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory: 12/05/2008 | Brentwood, MD 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. En/ r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hart failure dist only one cause on each line.

Immediate C het, (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, reading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) es that the death certificate be executed Hypertension Necley (Mount J. Box 68760, Spivision of Vital Records, P.O. Box 68760, and burial-trai Due to (or as a consequence of): Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician: The 2 No 1 □ Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎛 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and the 29d. Date signed (Month, Day, Year) D53691 Dec. 01, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D. 3200 Tower Oaks Blvd. #110; Rockville, MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 04 2008 Registrar

DHMH 17 Rev 1/2001

Jerome Peter Holmes Baltimore, Maryland 21215-0036

Division or Vital Records. P.O. Box 68760.

	For State Registrar	State of Maryl		epartment of I Certificate of		Mental Hy	giene Reg. No	2000	1:0585	1
	Decedent's Name (First, Middle, La	st)				2. Date of D		,	3. Time of Death	-
an	TERONE PETER	HOLMES				December	Da		11:30 A <sup>M</sup>	
al er	4a. Facility Name (If not institution, gire			4b. City, Town, o	or Location of Dea			. County of Death		_
e <sup>to</sup> —	,		yrs. last birtl		e de Gra If Under 24 Hrs Hours Min	8. Date of B	ay, Year)	Cot	pplace (State or Foreign untry)	-
	Usual Residence of Decedent					108/13/	1943	3 Ma	cne	_
_	10a. State 10b. County	100	. City, Town	or Location					10d. Inside City Limits	
Director	MD Harfor	d	Havi	e de Grace			10 01		1 □ Yes 2 No	_
	10e. Street and Number	,		10f. Zip Code	_			tizen of What Cou	untry?	
Funeral	306 Robinhood Ro	12. Was Decedent Ever	in U.S.	2107		Specify Yes or N		I.S.A. 14. Race - Amer	ican Indian,	_
	1 ☐ Never Married 2 ☐ Married	Armed Forces?		13. Was Decedent of I		rto Rican, etc.)		Black, White	e, etc.	
by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:197	9-91	1 ☐ Yes 2√☐ No	Specify:			Specify:	White	
Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Decedent's Usual Occu (Give kind of work done	during most of we	orking	16b. K	Kind of Business/I	ndustry	
шþ	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	rd)	v		_		
	17. Father's Name (First, Middle, Las	*)		Inited Stat		me (First, Middl		BOVETHME!	<u>ut</u>	_
To Be	Homer W. Holmes	,				F. Leav		, comano,		
Ě	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street				or Town, State, Z	ip Code)	-
	Patricia A. Dano	(Sister)	80	) Lombard R	oad, Car	ibou, Ma	rine	04736		
	20a. Method of Disposition	20	b. Place of cemeter	Disposition (Name of , crematory or other pla	ice)	Date	20c. L	ocation - City or 1	Γown, State	_
	1 ☐ Buria! 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.	Inemoval from State		ris & Co.	Inc. 12/	9/2008	West	t Cheste	r. PA	
	21 Signature of Funeral Service Lice			22. Name and Addre	ess of Facility Ze	llman Fi	inera	ul Home,	P.A.	
	/ raia C.	Allm	an	123 S. Wa				ire de Gi	race, MD	
	23a. Part1. Enter the disease, or cor shock, or heart failure. Listlonk Immediate Cause (Final disease or condition resulting in death)	a. NAMA	CNSE	s - HASLVA	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	_
	Sequentially list conditions.	b. CHAINC Due to (or as a cor	KINNO	7 15 ERSE						
Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	iseque, ice o	i).				- 1		
хап	Cause (Disease or injury that initiated events resulting in death) Last	c. M/En Tm		f):						_
_		-d.		,	è					
edic		d								_
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y			23d. Date of delive Month	very Day Year	
	Part II. Other significant conditions	contributing to death but no	t resulting in	the underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
d-by						1 🗆	Yes 2	2 No 3 Pro	obably 4 ∐Unknown	
Completed				_		24a. Wa auto per 1∏ Yes	opsy formed?	prior to o death?	topsy findings available ompletion of cause of	
Be	25. Was case referred to medical examiner?			178	26. Place of De	eath (Check only				_
To	1 ☐ Yes 2 ☑ No			Patient OL BOA	ner: 4 Nursing	Home 5 Res	sidence	6 □Other (Spec	eify)	
	27. Manner of Death  1. ✓ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. T	jury Wo	nryat rk? ]Yes 2 ∐ No	28d. Describe	how inju	iry occurred		
Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	90 Place of injury	At home, far pecify)	m, street, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Ru e)	ral Route Number,	
Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysiclan: To the best of my miner: On the basis of exal and manner stated.	knowledge, mination and	death occurred at the tile. It is in my	ime, date and plac opinion, death oc	ce, and due to the	e cause(s e, date an	s) and manner as nd place, and due	stated. to the cause(s)	
Me	29b. Signature and title of certifier	«		29c. Licens			29d. Da	ate signed (Month	n, Day, Year)	Ī
	1 Selved In	1 mm		133	3088		12	- (8/ox		
	30. Name and address of person who	completed cause of death	(Item 23a) (1	Type, Print) 321 Rivers	de Park	Way P	sel c	m cm	0 21017	
te	31. Date filed (Month Pay, Year)	2008 32. Régistrar's S	Signature	- 111 V(13)	JU IUIF			-111		-
ar	36.0 V 4	CONO MARIA	o AF	SARAGE A.P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar amend item 5,QACHD,per FH,12/19/08 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician ecem CHERYL SUSAN HUNTER /Medical 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TALBOT EASTON MEMORIAL HOSPITAL EASTON 5. Social Security Number 216-44-7911 <del>218-34-93</del>98 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F 60 PENNSYLVANIA SEPT. 14, 1948 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be restilled at Director 1 ☐ Yes 2X No MARYLAND | QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 BENNETT POINT ROAD 21658 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 □ Yes 2X No Specify: ð Specify: WHITE permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (3-4or 5+) Elementary/Secondary (0-12) MANAGER RESTAURANT Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be HOSEY BENJAMIN GILMER MARJORIE BLACK ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 BENNETT POINT ROAD, QUEENSTOWN, MD 21658 JAMES E. HUNTER, JR./HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) (Name place) 20c. Location - City or Town, State DECEMBER 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 MEMORIAL PARK EASTON, MARYLAND 21. Signature of Funeral Solvice Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** barac hnoid disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 2 2 40 Division of Vital 2 -NO Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No patient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Date of Injury (Month, Day, Year) funeral 27. Manner of Peath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DR. DENNIS DESHIELDS

DEC

32.

2008

Régistrar's Signature

31. Date filed (Month, Day, Year)

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**ORIGINAL** 

219 S. WASHINGTON STREET, EASTON, MD 21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician**  $\mathbf{P}^{\mathsf{M}}$ June December 2008 Jensen 10, 8:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 18917 Dover Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗑 F 149-38-9229 60 Director 1, 1948 New Jersey Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No Funeral Director PA Franklin Fayetteville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 17222 1021 Black Gap Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Transcriptionist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Walter Neugebauer June Ida Wortman မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau 4936 Red Hill Road, Keedysville, MD Cynthia E. Neugebauer/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 12/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Men 1601 Pennsylvania Ave., Hagerstown, MD Approximate Interval Between Ponset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consent ence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Ö 9□Unknown 9 Unknown or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 ₩6 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Dether (Specify) Certification: To After this funeral o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death
To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a, Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check onl one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ses 111 MA 11110 deru 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** <sup>Day</sup> 2008 Marta Jimenez Dec. 02, 16:15p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) Year) 1 □ M 2 🕅 F Months Days Hours Yrs. 219-96-8111 Director 07-04-1936 El Salvador Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Eventhar must be notified at Funeral Director 1 X Yes 2 ☐ No Prince George's Hyattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1410 Merrimac Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 □ Never Married 2 X Married Specify: White 1 X Yes 2 □ No Completed by 3 ☐ Widowed 4 ☐ Divorced salvadoran 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Housewife Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Roque Salamanca Hortencia Rodriguez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Merrimac Dr. Hyattsville, Maryland 20783 Carlos Salamanca 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 12-11-08 El Salvador 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3447 14th St. N.W. Washington DC 20010. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner patocoll Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Ahours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>8</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? 2 🗹 No 1 □Yes 2 ☑ No 1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Valeshoi 03 amkon 12 80 D0064289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varsha Vanikar, M.D. 7503 Surratts Rd., Clinton, Md. 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signat State

DHMH 17 Rev 1/2001

Registrar

DEC 0 5 2008

			For State Registrar	-	affment of H rtificate of L		tal Hygien Reg. N		Incon
	Dhysisi	400	Decedent's Name (First, Middle, Last)				Date of Death	Day O Year	3. Time of Death
	Physicia /Medic	al	JOHN W. JACKSON		4b. City, Town, or			2008 Lc. County of Deatl	5:10 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Lorien Nursing Home		Mt. A			CARROL	
1	Funeral Director			e (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.   8 I	Date of Birth Month, Day, Yea uly 13	Q Rint	nplace (State or Foreign Untry) Maryland
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla f sho	'n	MD Montgomery		thersbu	ra			1 TYes 2 No
	r 28a-	Director	10e. Street and Number	00.3	10f. Zip Code	<u> </u>	10g. (	Citizen of What Co	untry?
	th with	al D	101 Odendhal Ave,		208			U.S.A.	
336	be filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1	No I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: B	
21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occupa	lurina most of workina	16b.	Kind of Business/l	Industry
121	within ene. <b>than</b> "	du	Elementary/Secondary (0-12) College (1-4or 5	5+)	DO NOT use retired	•	В	echtel	Corp.
d 2	Hygi Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fil	st, Middle, Maid	en Surname)	
/lan	hould be id Mental marked o matic ev	To B	John M. Howard					. Jacks	
, Maryland	12s han 7 Is trau		19a. Informant's Name/Relationship (Type. Print) Carlyn Moyer (P.O.A.)	l .	-	and Number or Rural Ro ty Ct, Ge	rmanto	wn, MD	20874
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature 1 Funeral Service ☐ Inse	Gate of	matory or other plac E Heaven 2 Name and Addres	Cem 12/4	/08 S	NERAL H	pring,MD OME, P.A.
	Physician /Medical		23a, Part1. Enter the disease, or complications that caused shock, or heart failure. List only one caus, or each lift immediate Cause (Final disease or condition resulting in death)	ral Kles	ter the mode of dyin	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Examiner		Due to (or as	a consequence of):	fullore	o			week
	pa ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	N. I.	abolesal	1 DIL		week
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as	a consequence of):	CHIONIC	obstructions sease	R WIME	DUREY.	415
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		Medi	IE EEMALE:						/
.O. Box	The law requires that the death certifi tite has been signed by the attending I page 2 should be detached for use as	Physician/M	23C. If yes, outcome	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
Д	quires that n signed by uld be deta	þ	Part II. Other significant conditions contributing to death b	out not resulting in the C	underlying cause give	en in Part I.			the cause of death? obably 4 2 Unknown
I Records,	The law require ate has been sig page 2 should b	Completed	Prostate cancer, po	an Dal	rathy,	De TT	24a. Was an autopsy performed 1∐ Yes 2 🔐	? prior to death?	topsy findings available completion of cause of
Vital	sician: The certificate ha rector, page	Be C	25. as case refer ed to me ical examiner?	,	low	26. Place of Death (C	heck only one)		
o_	this aldi	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpation  27. Manner of Death 28a. Date of Inju			4 Phursing Home	5 Residence		cify)
	ding J. Aftel fune	tion:	1 ■ Natural 5 □ Pending (Month, Da 2 □ Accident investigation		Wor	yan k? Yes 2 □ No	Describe now ii	nary occurred	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	jury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office	28f.	Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,
1	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medicat C	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or i					
	To the Within To the Comp.	Me	29b. Signature and title of certifier Rulley	MID	29c. Licens	14749	11	Date signed (Mont	2008
_			30. Name and address of person who completed cause of of AHIEW Reilly, MID 801  31. Date filed (Month, Day, Year)  33 Regist  DEC 0 4 2008	Toll House	Print) Ave, I	)-1, FRED	ecick,	Mel 2	1701
	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 0 4 2008	rar's Signature	medi	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 10:48 P M FRANKLIN EUGENE KLINE Decembe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL BOONSBORO WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 1X M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 219-34-5684 71 SEPT. MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6214 CLEVELANDTOWN ROAD 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2√∑ No Specify: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 FOREMAN CONSTRUCTION COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WOODROW ALVEY KLINE MAY A. PRYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES A. KLINE, WIFE 6214 CLEVELANDTOWN ROAD, BOONSBORO, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 12/6/2008 FREDERICK, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If leam 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its froutent base until the profiled at

Baltimore, Maryland 21215-0036

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Box 68760

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Records,

**Division of Vital** 

Hospital or Attending

Physician

/Medical

10a. State

Director

Funeral

Completed

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**Examiner** 

**Funeral** Director

attending physician and for use as the burial-tran

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1	23a. Fir 1. Enter the disease, or com	iplications that laused the death. Do not enter th	Old National P e mode of dying, such as cardiac	ike Boons or respiratory arrest.	50	21713 Approximate
	shock, or hear falure. List only Immediate Cause ( do l disease or condition resulting in death)	each line.	eumonia	, , , , , , , , , , , , , , , , , , , ,		nterval Between Onset and Death
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):  Due to (or as a consequence of):	HearT BI	ock		
Evallin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. STAPH AVELS  Due to (or as a consequence of):	Sepsis			
2	•	_d				
I y si ci ai i i i ii	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month D	/ ay Year
ובח וחא בו	Quadriplegi		ying cause given in Part I.	n e	co use contribute to the	
	neuropani			24a. Was an autopsy performed 1 ☐ Yes 2	death?	y findings available bletion of cause of □No
	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)		
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	ome 5 Residence	e 6 ☐Other (Specify)	
-	27. Manne Death 1 Atural 5 Pending 2 Accident investigation		28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
	3 Suicide 6 Could not be determined		actory, office	28f. Location (Street City or Town, St	and Number or Rural I ate)	Route Number,
2000	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, gation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as sta and place, and due to ti	ted. ne cause(s)
1	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Da	ay, Year)
	Juma a	Decell	40061117	De	censer.	4,2008

DHMH 17 Rev 1/2001

Registrar

Hogers Town,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E. Anneton

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dec. 2008 8:26 PM 6, Henry Clay Kessler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Freeland 21626 New Freedom Road | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCt. 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 2 M 2 □ F 1937 Maryland 217-34-9320 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No Freeland Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21053 21626 New Freedom Road U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 ② Ses 2 □ No 9 6 1 − 19 6 4 − 19 6 4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other fraumatic event, the Modiful Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 2 3<sup>™</sup> Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine C. Brown Joseph W. Kessler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 180 Swetland Rd. Gettysburg, PA 17325 Joseph Kessler 20b. Place of Disposition (Name of 20a. Method of Disposition Dec. Data 11. 20c. Location - City or Town, State Susquenanna Memorial Gardens 1 Burial 2 Cremation 3 ARemoval from State \* 4 □ Donation 5 □ Other (Specify) 2008 York, PA 21 Sign the e of Funer I Se vice Lice see 22. Name and Address of Facility J. J. Hartenstein Mortuary, win 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tranediate Cause (Final disease or condition resulting in death) myscardial Physician /Medical Due to (or as a consequence of): CAD **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit DM P.O. Box 68760, 4 Due to (or as a consequence of) physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 90 2/ No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2K No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Tyes within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO05515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9600 foint Rd Howard 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12 Day 3:50 PM **Physician** Bernard Kasper /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Longview Nursing Home Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) June 24, 1922 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 € M 2 □ F 204-10-9381 86 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, it a Modical Examinar must be notified at 1 TYYes 2 □ No Directo MD Carroll WEstminister 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2710 Faithful Drive 21158 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status e filed within 72 hours after all Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beer Distributor Owner Beer Distributor 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked otheny injury or other treumatic event 17. Father's Name (First, Middle, Last) Be Frank Kasper Stella Not Available 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2710 Faithful Drive, Westminister, Maryland Janet Champness/Daughter 21158 20b. Place of Disposition (Name of comptery, crematory or other place)
Spring Hill
Cemetery 20c. Location - City or Town, State Shippensburg, PA 20a. Method of Disposition December 8, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas L. Geisel Funeral Home, Inc. 21. Signature of Euneral Service Licenses 333 Falling Spring Rd., Chambersburg, PA 17202 M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 Yes 2 No Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has b irector, page 2 sl autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗆 Yes 2000 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funerel 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Of in Romaning 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster PANSURIYA 349 malwim 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar 18

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December Dona Marie Kahl 10:10 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Year | 9. Birthplace (Statements) | Months | Days | Hours | Min. | Feb. 13, 1936 | Mary Tand 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 F 219-32-2854 72 Usual Residence of Decedent 10b. County 10c City Town or Location 10d. Inside City Limits Frederick 1 ☐ Yes 2 ☐XNo Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21703 6675 Seagull Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Anna Diffendal Emil Theodore Pacura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6675 Seagull Court, Frederick, MD 21703 Mr. Martin R. Kahl, husband 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory Dec. 10, 2008 20c. Location - City or Town, State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic breast disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

10a. State

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Funeral

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Completed

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Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Macifical Examiner must be notified at once.

Examine attending physician and for use as the burial-tran Physician/Medical signed by the a <u>۾</u> certificate has been s rector, page 2 should Completed this certific al director, Be Certification: To after death Director: d in by the f

Division of Vital Records, P.O. Box 68760,

Malignant Dleural 25. Was case referred to medical examiner? 1∐Yes 2DNo

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day, Year)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

00064741

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)
Misty Leigh Williams Frederick Memorial Hospital, Frederick Manyland 31. Date filed (Month, Day, Vear

State Registrar

Medical

DEC 1 8 2008



To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Earl Lanham 9 Dec 2008 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 447-2 Moores Mill Bel Air
If Under 1 Year | If Under 24 Hrs. Road <u>Harford</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 220-24-5294 80 6/17/1928 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD. Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 447-2 Moores Mill Road 21014 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1945 and 2 should be filed within 72 hours after 1X Yes 2 ☐ No I Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3X Widowed 4 □ Divorced Year or Dates: 1949 White al Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 0 Firefighter Baltimore County ath and Mental Hygie 27 is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P James Earl Lanham Margaret Hagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Department of Health a Important: If item 27 is any Injury or other trau once. Middle River, Kathleen A. Diehl (Dau.) 1010 Middle River RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 12/15/08 | Fallston, Maryland 21. Signature of Fundral 3 rvige Ucensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malnut, Hon min uns **Physician** /Medical Due to (or as a consequence of) **Examiner** Propertia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cancer Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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12/12/08

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S Regis			31. Date filed (40)	1 8 Z0	10	Dister	Territor and	's signature		CONTROL OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR				•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sarah <u>Virginia</u> Levenduski December 6, 2008 7:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner South Washington Edgewood Dr. Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 💢 F Director 261-20-7508 92 Dec. 21, 1915 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. South Edgewood Dr. 21740 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Domestic marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: if Item 27 is marked o any Injury or other traumatic eve James Holbert McClure I1a Kelley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levenduski / Daughter Deltah 438 South Edgewood Dr. Hagerstown Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1XBurial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 12/10/2008 | Hagerstown, Maryland 21. Si of Funeral Service Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subben 01 /Medical sile Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit that the death certificate be executed Box 68760, 5 Due to (or as a consequence of): Physician/Medical attending properties for use as use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 movths? 1 ☐ Yes 2 ☐ Yo Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe certificate Division or Vital 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only phe) Other: 4 \( \sum \) Nursing Home 2 100 ٩ 1 Tes 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 5 D Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 110

egistrar's Signature

11110

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical CAMPAS ROLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. 10,2008 **Physician** BERNES JANE MARTIN 4:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death CHARLES 4b. City, Town, or Location of Death Examiner LA PLATA GENESIS LA PLATA CENTER 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7-13-1927 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 ▼ F Months Days Hours Min. TEXAS 81 579-38-4599 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar mast be notified at LA PLATA 1 Yes 2 □ No Director MD. CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 U.S.A. 1 MAGNOLIA DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ∑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD FRANKLIN REPASZ SARAH FRANCES TURNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar permit. Pages 1 an.
Department of Healt
Important: If Item 27
any Injury or other tr.
once. POMFRET, MD. 20675 CHERIE NUTWELL-DAUGHTER 9265 LUFTSCHLOSS DR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD. VETERANS CEM. 12-17-08 CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MQQ479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 Une 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CIRRHOSIS w may disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Dunknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an certificate has page 2 autopsy The perform 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie DEC 10 2008

Registrar

State

31. Date filed (Month, Day, Year)

+ #102 Waldoof pul 21602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/02 32. Registrar's

Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:30 A M KEREN MACARTHY /Medical RCEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 □ M 2 🕏 F Director 578-15-1280 MAY 29 1941 SIERRA LEONE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Extrain er must be motified at once. Director 1 X Yes 2 □ No PRINCE GEORGE"S MD RIVERDALE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6103 63rd AVENUE 20737 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dear the 2 yrs CERTIFIED NURSE ASSIST. PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EUGENE S. OLU-JONES SUSAN STAFFORD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENIA MACARTHY/DAUGHTER 7628 MANDAN ROAD GREENBELT, MARYLAND 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 3 Removal from State FAMILY PLOT 12/20/2008 FREETOWNE, SIERRA LEONE 21. Signature of Emeral Service Lic 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 232 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastro intestinal **Physician** 11 PPo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an this certificate has ral director, page 2 s autopsy 2 **N**O 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 217146 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 267810 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIOSUM. 8118 Good Luck Rd., Lanham, mD. 20706 AZEE 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State DEC 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > ( 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Dora Martha Davis McDonald 11/27/2008 6:45 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Fort Washington Prince George's 9304 Fort Foote If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 3kF Director Franklinton, NC 246-48-5581 83 9/22/1925 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1√2 Yes 2 □ No Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9304 Fort Foote 20744 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1∐Yes 21k∏No Specify: Black Specify ≦ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Healthcare marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvis P. Davis Viola Massenburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 27 9304 Fort Foote Road Fort Washington, Maryland 20744 Janice White / Daughter Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Walnut Grove Baptist | 12/8/08 4 ☐ Donation 5 ☐ Other (Specify) Louisburg, NC 21. Signature of Funeral Service Licens le 22. Name and Address of Facility Pope Funeral Homes, P.A. 20401181 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, occupations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. Last only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE MYELOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ed by t detach ۵. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy Hospital or Attending Physician: The certificate 1 □Yes 2X No 1 ☐ Yes 2 ☐ No **Division of Vital** director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation n 24 hours alter he Funeral Director: Af mately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 2.

State Registrar

(Check only one)

29b. Signature and title of certifier

1150 Bindu C. Joseph Varnum St. N.E. Washington, D.C. 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signat DEC 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD 33755

29d. Date signed (Month, Day, Year)

12/3/2008

			For State Registrar	State	of Marylar		artment of F		and Mer		giene Reg. No.	2008	40500
			Decedent's Name (First, Middle,	Last)	-					Date of Dea	ath		3. Time of Death
	nysicia 'Medic		Nellie	McNeil						Month OV •	28 <sup>Day</sup>	$2008^{\text{Year}}$	13:30 M
~	xamin		4a. Facility Name (If not institution,	0	,		4b. City, Town, or	_	of Death			County of Death	
A.			Washington Adver  5. Social Security Number			In ad to indicate alone A	Takoma  If Under 1 Year		2/ Hre Lou	D-1 ( D:-N		tgomery	
	neral ector		579-30-7707	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs 89	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day Ly 28	, Year)	Cou	place (State or Foreign ntry) rolina
P			Usual Residence of Decedent					1	ψα.	Ly 20	1919	N. Ca	IIOIIIIa
arylan	dat d	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation					-	10d. Inside City Limits
he Ma	office	Director	MD Prince	George	s Hy	attsvi	11e 10f. Zip Code				10- 0''-		1 XYes 2 No
with 1	Ped	ä										en of What Cou	nu y :
Jeath	18 2	Funeral	6500 Riggs Road  11. Marital Status		cedent Ever in U	J.S. 13. \	20783 Was Decedent of H	lispanic Orig	gin? (Specify	Yes or No-	USA 14	4. Race - Ameri	can Indian,
d Z1Z13-UU30 filed within 72 hours after death with the Maryland Hygene.	or lie		1 ☐ Never Married 2 ☐ Marrie	Armed F ed 1 □Yes If Yes, 0	2X No	-	fYes, specify Cuba I⊡Yes 2⊡xNo	an, Mexican, Specify:	i, Puerto Rica	ın, etc.)		Black, White,	_
DOSO hours af	LEXX	d by	3X Widowed 4 □ Divorced	Year or	Dates:							Specify: Bla	
137 n	edica	Completed	15. Decedent's (Specify only highest	Education grade completed	)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most	of working	1	16b. Kind	d of Business/In	dustry
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filed Hyg	vent,	Be C	17. Father's Name (First, Middle, L.	ast)				18. Mother	r's Name <i>(Fir</i>			_	abery
Ments	atic e	ToE	Oscar Page					Kath	leen (	Gilles	pie		
2 sho	a i	Ċ	19a. Informant's Name/Relationshi			1	g Address (Street				. ,		o Code)
C, R	thert	1 3	Robert E. Black 20a. Method of Disposition	:/Persona			Kansas Av	re. N.	E. Wa	sh.,		20012 ation - City or To	
ages int of	0.0		1⊠Burial 2 ☐ Cremation 3		n State	cemetery, cren	natory or other place on Nation			2009		•	,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	in juri		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Wa	-	. Name and Addres					land, M	
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			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the dea	th. Do not ent	er the mode of dyin	ng, such as	cardiac or res	spiratory am	re <i>s</i> t,		Approximate Interval Between
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The	ral director, page 2 sl	Co								perfori 1 □ Yes	med? 2.2No	death?	2 □ No
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendent.  Of the Funeral Director: After this certificate has been stoned by the attending physician and	etely f	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying  2 ☐ Medical E	xaminer: On the	ne best of my kn basis of examin Inner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my o	me, date and pinion, deat	d place, and th occurred a	due to the o	cause(s) a late and p	and manner as s place, and due to	stated. o the cause(s)
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,			30. Name and address of person w	ho completed car	use of death (Ite	m 23a) (Type,	Print) 7600	Carro	11 Ave	Ta	koma	Park,M	D 20912
	Stat	-	31. Date filed (Month, (Day, Year)  DEC 0 4	2008	Registrar's Sign	ature 4	adi J		1		y 1		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11/26/2008 Josyf Moroz 00:08a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Elkton Cecil 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2 □ F 9/6/1922 179-16-9916 86 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1XiYes 2 □ No Director Elkton MD Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Laurel Drive 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Welder Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Alexander Moroz Petrunela Kapko 19a. Informant's Name/Relationship (Type. Print) in law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 475 Aviation Avenue Department of Health a Important: If Item 27 is any injury or other trainonce. Sanda Restaneo - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris 12/5/2008 West Chester, PA 4 ☐ Donation 21. Signature of Juneral Service Licen ee 22. Name and Address of Facility CC0442 Beeson Funeral Home of Newark 2053 Pulaski Highway, Newark, tolet DE 19702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 70 /Medical Due to (or as a consequence of): Examiner つしにいろいろころ Sequentially list conditions, large to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the bunial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð INDERMATERMIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed アミュー コロ 2√No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 ☐ Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier A Cimile. This 29c. License number 29d. Date signed (Month, Day, Year) NAMITA TULL D0063730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 HUSPITAL , ELIZTON しいいいい 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2 November 2008 **Physician** 8:45 PM Florence E. Mason /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Heritage Harbour Health Annapolis & Rehab | Months | Days | Hours | Min. | 8. Date of Birth (Months, Pay, 1994) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 ☐ M 2√2 F 218-76-2438 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the live item Examiner must be notified at No Yes 2 □ No Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 130 Hearne Rd. Apt 1 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2√□No Specify. ρ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Λ Homemaker None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Nelson James Mason ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances Williams (Sister) 21403 Annapolis, Md. Victor Parkway 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Chews U.M. Church 12-1-08 West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windlame Reddee of &cilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Physician disease or condition resulting in death) TOURS UL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a nonsequence of: Examiner The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): ttending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ts been signed by the should be detach€ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 2 No certificate 1 ☐ Yes 2 No 1 □Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig gause of death (Item 23a) (Type, Print) 30. Name and address of person who completed (way 50 Olyn Byrne MD 2106/ State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

4		1- State of Maryland / L 1- State of Maryland		2	2. Date of Death		3. Time of Death
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/Medic		4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Death	
7		The Johns Hopkins Hospital	Baltimore			None	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	irthday) If Under 1 Year   Months Days	If Under 24 Hrs. 8	8. Date of Birth (Month, Day, Yea	9. Birthpla Country	place (State or Foreign try)
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show		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town				10	l 0d. Inside City Limits
8a-f		MD Howard Fulton					1 □ Yes ¾ŢNo
if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10e. Street and Number 11895 Scaggsville Rd.	10f. Zip-Code			. Citizen of What Country	ry?
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Department of Heal Important; If Item 2 any Injury or other once.		Mary July M01411	4112 Old C	Columbia Pi	ike, Elli	icott City,	, MD 21043
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		1 - State Registrar Ce.  1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	Reg. No			
	ician			December 3, 2008		4:45 P M	
	dical	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
1		Dove House	Westminster  If Under 1 Year   If Under 24 Hrs.		Carroll	loop (State or Fareign	
Fune Direct		5. Social Security Number 6. Sex 1 $\cancel{X}$ M 2 $\square$ F 7. Age (In yrs. last birthday) 63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You Apr 28,	1945 Nort	lace (State or Foreign try) h Carolina	
ъ		Usual Residence of Decedent				0d. Inside City Limits	
farylar fshov	o.	10a. State 10b. County 10c. City, Town or Lo			'	1 ☐ Yes 2 ☐ No	
r 28a-	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?	
th with 23a o	ralo	14300 Northwyn Drive	20904	US	SA		
er dea items	Funeral	11. Marital Status  1 □ Never Married	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
urs aft	yd B	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1964-70	1 □Yes 2 No Specify:		Specify: Whit	·e	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. when "natural", or items 23a or 28a-f show ant, the Marical Examinar mat be notified at the Marical Examinar mat be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Ind		
within ene. than	amo	Elementary/Secondary (0-12)  College (1-4or 5+)  Vice	ponoruse retired) President of Human	1	althcare		
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12 sho th and 7 Is m traum			ng Address (Street and Number or Run D Northwyn Drive S				
s 1 and 1 Heal		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or To		
Page ment o		1 I I Burial 2 Di Cremation 3 I I Bernoval from State 1	el Crematory 12/0	5/08 00	lenton, MD		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be rediffed as any injury or other traumatic event.	DCe.	21. Signature of Funeral Service Licensee	2. Name and Address of Facility Ding Home Crematio	n Service	P.O. Box	784	
402	ŭ	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	everly L. Heckrott			Approximate	
Physicia	an l	shock, or heart failure. List only one cause on each line.	doru k	ilure		Interval Between Onset and Death	
/Medic	al	disease or condition resulting in death)  a. Due to (or as a consequence of);		1 .			
Examin		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	age Demen-	IA			
cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
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F FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Festal death   5   Other (specify)   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobaccontributing to death   23e. Place of Death   23e. Place of Death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Place of Death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Place of Death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Place of Death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Did tobaccontributing to death   23e. Did tobaccontribut					23d. Date of delive	ery	
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w requires that the de been signed by the should be detached	Phy	Fait ii. Other significant conditions contributing to death but not resolute in the c	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?	
quires en sigr uld be	Aq pa	Klush lame		1 ☐ Yes	2 No 3 Prob	ably 4 Unknown	
e law re has bee	plet			24a. Was an autopsy	24b. Were auto	psy findings available npletion of cause of	
: The icate h	24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   24b. Were autopsy findings prior to completion of death? 1   Yes 2   No 3   Probably 4						
siclar s certif irector	e 6 MOther (Specif	hoonios					
ig Phy ter this	n: To	injury occurred	nospice				
tendir eath. tor: Al	catic	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident investigation 3 Suicide 6 Could not be	Work? M 1 □Yes 2 □No				
lor At after d Direct	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.							
the Hi hin 24 the Fi	Medical	one) and hanner stated.  29b. Signature and title of certifier	29c. License number		. Date signed (Month,		
₽ ₹ <b>₽</b> 8		29b. Signature Indititle of certifier MD	D3539	8	cember 4,		
(2+1)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print\	•			
La	•	31. Date filed (Month, Day, Year)  32. Registrar's Signature	COURSTREE!	JOSTHIU	Ster IMDG	10/	
Reg	State istrar	DEC 0 5 2008 Seems &	bark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December b, 2008 **Physician** 30 PM Robert William Nichols /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hagerstown 18804 Dover Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthdav) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Aug 9,1931 Maryland Director 219-20-2962 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Sm 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Hagerstown Maryland | Washington Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 18804 Dover Drive 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12X9'es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Project Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Nichols Mary Forcino ဂ Pasquale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 18804 Dover Drive, Hagerstown, Maryland 21742 Gloria Ann Nichols/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland 12-8-2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple 5 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed tours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

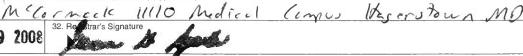
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Registrar

31. Date filed (Month, Day, ) 0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



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				artment of Health and Me	ental Hygien	2009 50407		
	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month D	ato of Dooth 2 Time of Dooth			
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	r death with the Maryland tems 23a or 28a-f show	5	10a. State 10b. County 10c. City, Town or L Maryland Anne Arundel Glen B			10d. Inside City Limits 1 ☐ Yes 2 📉 No		
	the M	Funeral Directo	10e. Street and Number	10f. Zip Code	10a. C	Citizen of What Country?		
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altimore,	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	natory or other place)	5-08 Da	vidsonville, Md.		
Balti	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. Once.			mname இடிகின் s of EaciliSons 121 West St. Anna				
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	cate be executed physician and the burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	29a. Certifier  (Check only one)  1 SertifyIng Physician: To the best of my knowledge, deal check only and local Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an ovestigation, in my opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)		
	vith To t	Σ	29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)		
	Os an	,	30. Name and address of person who completed cause of death (Item 23a) (Type	H0052843	11	-25-2008		
	A CON	V	Dr. Reten Sursy 4000 M	ucheleville Rd	, Ste B	422 Bowle no Zolli		
	Sta		31. Date filed (Month, Day, Year)  DEC 0 2 2008  32 Registrar's Signature	4.				
	Registr	ar	DEC O & LOUD PRODUCE ST.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ervin James Poling, Jr. 10:07 A 2008 /Medical December 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 1519 Clayton Rd. Joppa If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year 6/13/1946 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** West Virginia Months 15 M 2 ☐ F 62 Director 236-70-8425 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Harford Joppa 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21085 U.S.A. 1519 Clayton Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygien. A programment of Health and Mental Hygien. Important: If flem 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examples. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give U.S. Army Year or Date U.S. Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: Whtie ğ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equip oper. Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ervin James Poling, Sr. Olga Norman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1542 Deerfield Rd. Darlington, MD 21034 James Eades (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 12/16/08 Aberdeen, MD 4 Donation 5 Dother (Specify) Tarring-Cardo Tuneral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signatur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1 | Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide 29a. Certifier TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0028412 DECEMBER 12,2008 PHYSTUIAN 441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PITTUIP WINTPUNTN, 6025, ATMCOD ROND, BIEL AZR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LUCILLE DECEMBER 4. 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BURNIE Anne SALTIMORE WASHINGTON MEDICAL CENTE If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-28-8265 Days Months 1 □ M 2 🗹 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 1 ☐ Yes 2 No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st important: If item 27 is marked other than "natural", or item 27 is marked other than your other traumatic event, Ite Medical Examiner must be notified once. Funeral Director Zip Code 10g. Citizen of What Country? 10e. Street and Numb 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced of Health and Mental Hygiene. If item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . KEDMOND Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 EVERHILL RD. GLENBURNE, MD. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 DOther (Specify) PASADENA, MD. 21122 23a. Part1. Enter the disease, or complice shock, or heart failure. List only Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final OBCIENTINE FILMOMAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseductive of) burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy certificate 2 **☑**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

The law requires that the death certificate be executed Box 68760. Ö ۵ Records, of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Division

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

State Registrar Name and address of person who compl

31. Date filed (Month, Day, Year,

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ted cause of death (Item 23a) (Type, Print) Geograf

32. Registrar's Signatur

29d. Date signed (Month, Day, Year)

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John Lee Philhower		State of Maryland / Departmen	e of Death		2008 4061
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		645 Knight Island Road Glen 9 Social Security Number 6. Sex 7. Age (In yrs. last birthd		Date of Birth (MM/DD/)	(YYY) g. Birthplace (State or
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E » E 8	×	29b. Signature and title of certifier	O.C.M.E.		cember 8, 2008
		(almi)	1/		
		30. Name and address of person who completed cause of death (Item 23)	111 Penn Street, Baltimore, MD 2	1201	
		Zabiullah Ali, M.D. Assistant Medical Examiner	TITT CHIT STEEL, DAMINOIS, MD 2		
	State	31. Date filed (Month, Day, Year) 6 2008 32. Registrar's Signature	& specific		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gilda A. Parker 1305 29,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Rehab & Nursing Ctr. lisburg 10/120mica 5. Social Security Number Year If Under 24 Hrs Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF Director 58 VA Nov 2, 218**–**50–2025 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County artment of Health and Mentral Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 629 Decatur Avenue 21804 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Blind Industries 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil.
Department of Health and Mental H.
Important: If item 27 is marked oth
any injury or other traumatic event Be John Parker, Sr. Eva Irvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 Decatur Avenue, Salisbury, MD 21804 John Parker, Jr./brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Green Acres Mem Park 12/08/2008 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home alsou 1618 West Rd., Salisbury, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) R **Physician** ac eas CAPE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an was u. autopsy performed? Yes 2 No After this certificate has 1□ Yes Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 | Yes 2 | No P 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ...errospital or Attending Ph within 24 hours after death. To the Funeral Director: After this completely filled in her. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ataled. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) **DEC 0 4** 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William H. - Robins, M.D. 200 Civic Ave. Salisburg

1M0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2004 6:00 P. M Beatrice B. Pomerantz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√√□ F 88 New York 9-12-1920 Director 067-12-8094 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Examiner must be notified at 1 Yes 2 No Director 28a-f Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 20852 U. S. A. 6121 Montrose Road Completed by Funeral 1 and 2 should be filed within 72 hours after death. Health and Mental Hygiene. em 27 Is marked other than "natural", or items 233. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Wacs 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates: WW 2 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Pomerantz Ben Pomerantz ဂ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 6038 Westchester Park Drive, College Pk., Md. 20740 Karyn L. Pomerantz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/4/2008 Falls Church, Virginia King David Mem Gdns 21. Signature of Funeral Service License 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald ( 1091 Rockville Pike, Rockville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cardio-respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cerebrovascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 3□ DOA 1 ☐ Yes 2√ No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural Injury 5 Pending s after dea. 1 ☐ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of p 29d. Date signed (Month, Day, Year) 8 0055362 December 1, 2008

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 4 2008

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Registrar's Signature

ath (Item 23a) (Type, Print)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	ر 5	an ar rrial-tr	Ĕ	resulting in death) Last Due to (or as a consequence of):					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	9	ate br	ical	d					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	5	the de	ysic	1 Yes 2 No 4 Pregnant at time of death 5	☐ Other (specify)		World	Day	Ja:
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	r.	that the ed by detac			underlying cause given in Part I.	23e. Did tobacci	o use contribute to	the cause of de	eath?
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	3	uires uires I sign Id be				1 ☐ Yes	2  No 3 Pro	bably 4√∑ U	nknown
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	>	ysici iis cel direc	0	. — — I Hospital:	Others		6 MOther (Spec	ity)Hoeni	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature	ָׁ	oital o		CO- Codifica					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 1355 Piccard Drive #100; Rockville, MD 20850  State  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature		omple	Mec	The marries stages.	29c. License number	29d. D	Date signed (Month	, Day, Year)	
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Registrar DEC 0 4 2008 December 19	F			31. Date filed (Month, Day, Year) 32 degistrar's Signature	este				
		Registra	ar	DEC 0 4 2008 Decree 10 19	1000-1-1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 December 02:00 AM Harry Losten Parrett 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil 109 Hunter Street E1kton 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours Min. Yrs July 8, Delaware 1920 88 219-05-5259 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Elkton Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 109 Hunter Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 NoUS Army If Yes, Give Year or Dates: 1942-45 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artillery Repairman US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Laird Elmer Parrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 109 Hunter Street, Elkton, Maryland Florence L. Parrett / Spouse 20b. Place of Disposition (Name of cogneter, crematory or other place) North fast Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5, 2008 North East, Maryland al Servic Livinsee Crouch Funeral Home 22. Name and Address of Facility 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unknown disease or condition resulting in death)

Physician /Medicai **Examiner** 

> and physician al

> attending p

the

signed by t

has t page 2 s

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

Physician/Medical

þ

Completed

Be

Certification:

Medical

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

**Examiner** 

10a. State

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the the temporant in the traumatic event, the the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event in the traumatic event.

death with the Maryland

within 72 hours after

Maryland 21215-0036

Saltimore,

Sequentially list condition any leading to immedicate. Enter Underlying Cause (Disease or injur that initiated events resulting in death) Last Examine

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🗷 No

ons,	
g Y	<b>-</b>

T a	Due to (or as a consequence of):	
b	Due to (or as a consequence of)	
c	Due to (or as a consequence of):	-
d		

yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 ☐ Other (specify)

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 bst 25. Was case referred to medical examiner? 26. Place of Death (Check only one) □ DOA

23e.	Did tobac	co use cor	ntribute to the cau	se of death?
	1 Yes	2 🗌 No	3 ☐ Probably	4 ☐ Unknown
0.4-	10/	0.41	Marin automore &	

Day

Year

24a. Was an	24b. Were autopsy findings available
autopsy	prior to completion of cause of
performed?	death?
1 ☐Yes 2 No	1 ☐ Yes 2 ☑ No
	4

1 ☐ Yes 2 🔼 No 27. Manner of Death 1 🖾 Natural

Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3
28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	

4 Nursing H	ome 5 Resid	dence 6	Other	(Specify)
ury at ork?	28d. Describe h	ow injury	occurred	

5 Pending investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide

determined

М	1 □Yes	2 🗆	]No
factor	v. office		

28c. Inj

1	28f. Location (Street and Number or Rural Route Number
	City or Town, State)

29a. Certifier

4 Homicide

28e. Place of Injury - At home, farm, street building, etc. (Specify)

		City of Fermi, Clare,
Certifying Physi	cian: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.
2 Medical Examine	er: On the basis of examination and/or investigation, in my opinion, death occ	curred at the time, date and place, and due to the cause(s)

	0/10/				
29b.	Signati	ire and	title of	certifier	ey
		_		A	U

and manner stated

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

4+IVA

			1 - State Amend #7,#	8,12-11-08,	per Fl	HDR Ce	CHD ate of	Death	aria ivio	Re	g. No. 200	8 405 15	
	Dhusisi		1. Decedent's Name (First, Middle	, Last)					2.	Date of Death	Day Yea	3. Time of Death	
	Physici /Medio		Sheila D. Pite	chford						Month Decembe	er 2, 200	8 2:50 P M	
- 4	Examir		4a. Facility Name (If not institution	, give street and numbe	r)		4b. City, Town, o		f Death		4c. County of De		
-			Casey House				Rockvil.				Montgome:	<del>-</del>	
	Funeral		5. Social Security Number	4 [7] M (127) E	ge (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day,	Year) (	irthplace (State or Foreign Country)	
н	Director		577-46-1042	7	5 -65	Yrs.			A			w York	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation		Ap	r. 2,	1933	10d. Inside City Limits	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandariant in ust be confilled at	5										1 □Yes 2X No	
	he M	ect	MD Montgor	nery	Che	<i>y</i> y Cha				1.00	g. Citizen of What (	Saurata 2	
	with t	늅	10e. Street and Number				10f. Zip Code					Southtry :	
	ath v	Funeral Director	3615 Shepherd S		. 5		20815		·	US			
	er de item	Ë	11. Marital Status	12. Was Deceden Armed Forces	?	5.   13.	Was Decedent of H If Yes, specify Cub	an, Mexican,	Puerto Ric	an, etc.)	Black, Wh	nerican Indian, iite, etc.	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dost Evanding must be notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes 2/1 If Yes, Give Year or Dates			1⊡Yes 2∭XNo	Specify:			Specify: T.1	nite	
215-0036	hou	ed	15. Decedent			16a. Dece	dent's Usual Occup	oation		1	6b. Kind of Busines		
15	in 72 	Completed	(Specify only highes	t grade completed)	5.)	(Give	kind of work done DO NOT use retire	during most	of working			•	
212	filed within Hygiene. vther than '	E O	Elementary/Secondary (0-12)	College (1-4or	3+)	Teach	er			F	Education		
b	filed I Hyg othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name (F		laiden Surname)		
Maryland	2 should be filed w n and Mental Hygie is marked other t raumatic event, in	To B	Joseph Anthony 1	Dovle				Jane 1	Donoh	ue			
ž	shound North	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number	r or Rural R	oute Number,	City or Town, State	, Zip Code)	
	1 and 2. Health a em 27 is		Kelly K. Pitchfo		r	12 B1	ueberry I	Ridge (	Court	Potoma	ac, MD 20	854	
ē,	s 1 a f He frem othe		20a. Method of Disposition		20b. Pi	lace of Dispo	sition (Name of matory or other place	20)	Date	. 2	20c. Location - City of	or Town, State	
9	e = 5		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		9 1		e Cremato		2/04/	08 F	Beltsville	⇒ MD	
Baltimore,	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service		, OILCS	22	2. Name and Addre	ss of Facility	,				
ä	permi Depar Impor any ir		1 Bour la 1	Ho. Witte	S MOTO	251 G	oing Home	e Crem	ation	Servic	ce P.O. ]	Box /84 11. MD 21029	
			Devely L. Heckrotte, P.A. Clarksville, MD 21  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between										
	Physician		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do Onset and Do										
	/Medical		disease or condition resulting in death)  Squamous Cell Carcinoma of the Larynx  Due to (or as a consequence of):										
-	Examiner			b. Corona			icosco						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ience of):	15Case_						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Atrial	Fibri	illati	on						
Ć,	execunary and an iaf-tra	Exa	resulting in death) Last		s a consequ								
68760,	icate be executed physician and the burial-transit	Medical		<b>L</b> d.									
68	tifical ng phy as th	edi											
Вох	eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ncy	75-1				23d. Date of c	delivery	
-	deatl e atte d for	Physician/	in the past 12 months? 1 □Yes 2 <b>X</b> No	1 Live birth	at time of de		⊒Ectopic pregnand ⊒Other <i>(specify)</i> _	су			Month	Day Year	
P.0	at the de by the tached	hys	9 ☐ Unknown	9 Unknown									
	res tha signed be det	by P	Part II. Other significant condition	ns contributing to death	but not resu	Ilting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use contribute	to the cause of death?	
ğ	quire an sig uld b	be				_				1 ☐ Ye	s 2 No 3	Probably 4 Unknown	
of Vital Records,	w requir s been s should	Completed								24a. Was an	24b. Were	autopsy findings available	
æ	: The law icate has b ; page 2 sh	шd								autopsy	ned? death		
tal	sician: The certificate rector, pag		25. Was case referred to medical					26 Place	of Death (	1 □ Yes 2 Check only one	XNo   1 □ Ye	es 2 No	
5	ysicii is cer direct	o Be	examiner? 1 ∐ Yes 2 XNo	Hospital: 1 Dinna	tient 2 🗆	ER/Outnaties	nt 3 DOA Oth				·	pecify) hospice	
ō	<b>ਨ</b> ∓ ਲ	n: To	27. Manner of Death	28a, Date of In	jury	28b. Time o					w injury occurred	Decily/ HOSPICE	
on	th. : After	tio	1 XNatural 5 Pending 2 Accident investig		ay, rear)	Injury		"κ? ]Yes 2∐N	No				
Division	Atter	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined   28e. Place of I	njury - At ho	me, farm, str	eet, factory, office	<u>.</u>	28f.			Rural Route Number,	
Ö	ial or Attendi s after death. al Director: A ed in by the fu	Certification:	4   Hornicide	building,	etc." (Specify	()				City or Town,	, State)		
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis	of my know	wledge, deat	h occurred at the ti	ime, date and	d place, and	due to the ca	ause(s) and manner	as stated.	
	he He in 24 he Fu plete	Medical	one)	and manner	stated.			opinion, deat	in occurred	at the time, da	ite and place, and d	ue to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier  Joce Cy n	2 Knissal	chois	, mi	29c. Licens		1,0		d. Date signed (Mo	•	
			) Joce Ly n	1000000	(4) (1	/	200	6471	46	De	ecember 3	, 2008	
	(1) a		30. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)	1 5	1	1 200	00055		
	L'AS		Jocelyne Kouatc				er Mill l	ka. Ko	ckvil	re, MD	ZU <b>&amp;</b> 55		
	Sta		31. Date filed (Month, Day, Year)		trar's Signat		Pare M.						
	Registrar DEC 0 5 2008 Marie & Jacks												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 4:16 ам En-De December 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5516 Dowgate Court, #109 Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours Min Director 342-82-2323 82 January 10, 1926 China Usual Residence of Decedent should be filed within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5516 Dowgate Court, #109 20851 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No à Specify 3 ☑ Widowed 4 ☐ Divorced Specify "natural" Asian Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Doctor Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B မ Wen-Fan Qin Shu-Wen Xin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is Flora Chen - Daughter other t 5516 Dowgate Court, #109, Rockville, Maryland 20851 t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department or Important: If any injury or 1 D Burial 2 Cremation 3 Removal from 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 12/05/2008 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thy one cause on each line. 23a. Part1. Enter the disease or shock, or heart failure. List Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Renal Cell Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🛭 No 1 ☐ Yes 2 No ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 To the I 29b. Signature and t of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35635 December 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D., 18111 Prince Philip Drive, Suite 327, Olney, Maryland 20832 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 04 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 9:50 AM Jeanette Darling ROBISON December 1 ,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕏 F 220-10-3214 90 Director Oct. 21, 1918 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Director Maryland Washington 1723Yes 2 □ No Hagerstown 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? 344 South Cannon Avenue 21740 U.S.A. Funeral or items. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married traumatic event, the medical Evanni 1 ∐Yes 2 v No Specify: à white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown cleaning self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Clarence Robert Feigley Inez Irene Linder ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vor of Health ar Pages 1 and 2 Donna Smith - daughter 9215 Jordan Road, Fair Play, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December Department of Important: If any injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial 10, 2008 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Le Vestel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

GH-1

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

of Vital Records.

**Division** 

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 8 2003

ar) 32. Resistrar's Signature

30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)

1124

10041131

UPBL COURT

Dec. 07,2008

HAGERSTOWN MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician James Leslie Roby, Sr. 2008 prember 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Fahrney Keedy Home Boonsboro If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 96 Director June 5, 1912 MD 214-07-2686 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 713 Interval Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21√2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary G. Butts John H. Roby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James L. Roby, Jr./Son 713 Interval Road Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 12/12/2008 Little Orleans, MD Martin Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Immediate Cause (Final disease or condition resulting in death) Metasto **Physician** /Medical Due to (or as a consequence of) Examiner 0. Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 6 9

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D1 15

31. Date filed. (Month, Day, Year) DEC 1 8 2008

			•
State of Maryland	Department of	Health and I	Mental Hygiene

Stephen Reduzzi		State of Maryland / Department of least tare of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / D			teg. No. 200	10 1.05 L	
Physician Medical Examine	/	Decedent's Name (First, Middle,Last) Stephen Reduzzi		2. Date of Dea Month Decembe		3. Time of Death	
ray.	4		o. City, Town, or Location of E Annapolis	Death	4c. County of Dea		
Funeral Director	- 5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 186–46–4663 1 N 2 F 38 Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min	rth(MM/DD/YYYY) 9. B 6/1969	Birthplace (State or Pennsylvani Country)	
d how any	-	Usual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location  Maryland Anne Arundel Annap				10d. Inside City Limits 1 XYes 2 No	
the Maryland a or 28a-f show	חופרור		10f. Zip Code 21401		10g. Citizen of What Co USA	ountry?	
Baltimore, MD 21215-0036 / 3 3 5 5 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Decedent of Hispanic Origin's, specify Cuban, Mexican, Portion 2 No. Specify:		White, etc.	erican Indian, Black, nite	
136 thin 72 hours a re. than "natura edical Examin	omprered by		s Usual Occupation (Give kin st of working life. DO NOT us		16b. Kind of Business		
21215-0036 Juld be filed within 7 Imental Hygiene is event, the Medica	ב מ	17. Father's Name (First, Middle, Last)  David A. Reduzzi		Name (First, Middle, Susan J.	Beal		
MD 2: and 2 should alth and M m 27 is m: aumatic e	ĺ	David A. Reduzzi/ Father 211-C	Address (Street and Number King George	Street, A	nnapolis, N	MD 21401	
altimore, mit. Pages 1 and ppartment of Heal nportant: If iten jury or other tra		1 Burial 2 X Cremation 3 Removal from State crematory or othe Kalas Crem	matory 1	Date 12/07/08	20c. Location - City  Edgewate	r, MD	
Balt permit, Departi Importi	-	1001/11als- 29	ame and Address of Facility 73 Solomons I	sland Rd.	Edgewater	, MD 21037	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter th failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	e mode of dying, such as card	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death	
	Jer	Sequentially list conditions, if any, leading to immediate  b. Probable dehydration.  Due to (or as a consequence of): should	associated w ler and chroni	ith fract c alcohol	ure of lef	t	
ansit de Alfrida	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			/00/00 FFF		
0, be executed siscian and burial - transi		X UNPENDED AMENDED PI line a-b, 2	27,28a-f, perm	nE, g88/ 1			
ords, P.O. Box 6876.  w requires that the death certificate is been signed by the attending phy should be detached for use as the bear of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the		past 12 months?  4 Pregnant at time of 5 Oth	al death 3 Ectopic p	pregnancy	23d. Date of delivery  Month Day Year  .		
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	2	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part		tobacco use contribute es 2 No 3 P	to the cause of death?	
Division of Vital Records, P.O rial or Attending Physician: The law requires that the safter death.  The law rector: After this certificate has been signed by the timeral director, page 2 should be detacted.	Completed				opsy prior to formed? death		
tal Reco	ခို မရ	25. Was case referred to medical examiner?   Hospital:   Inpetient   2   FR/Outpatient	26.Place of Death (C	theck only one)			
n of Virding Physical After this stuneral dir	의	1 ✓ Yes 2 No Imparent 2 Endoughert 2  27. Manner of Death 1 Natural 5 Pacifics  28a. Date of Injury (Month, Day, Year)  28b. Time of Ir	njury 28c. Injury at Work?		Residence 6 🗸 Otles how injury occurred t fell	her: Scene	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Certification:	2 X Accident 3 Suicide 4 Homicide  Pending Investigation Investigation 6 Could not be determined (Specify)  Pending Investigation FD 12/5/08 FD 2:2.2.  28e. Place of Injury - At home, farm, stree unk		28f. Location or Town,	(Street and Number or State) UNK	Rural Route Number, City	
To the Hospi within 24 hou To the Fune completely fi	Medical C	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.					
F % F 8		29b. Signature and title of certifier  Wayone Me Kerel	29c. License number O.C.M.E.		29d. Date signed (f		
		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore,	MD 21201			
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	7				
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8-09149 Frances Jean Ro	ober	Please Type or Print in Black Indelible Ink. Ensure All Copie  tson State of Maryland / Department of Health and Mental Hy		jible.				
rances ocarric		State of Maryland / Department of Health and Mental Hy 1-For State Certificate of Death Registrar	_	g. No. 201	18 4052			
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Deat	h	3. Time of Death			
Medical Exami		Frances Jean Robertson  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month December	4, 2008 4c. County of Dea	1601 hrs			
		16 2nd Avenue Southwest Glen Burnie		Anne Arundel				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	<b>⊣</b>	h(MM/DD/YYYY) 9. B				
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· 0		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
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Sa-f sh	ctor	Maryland Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	16 2nd Avenue Southwest Apt. C 21061		US.	A			
1 with ms 23 be no		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		14. Race - Ame White, etc.	erican Indian, Black,			
r deatl	Funeral	1 Yes 2 X No	radii, etc.)	f.)	hite			
ırs afte ural",	ā	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	Specify: W 16b. Kind of Busines:				
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retir			, massey			
036 vithin ene. er tha	du	12 Customer Service Representat		Printing				
21215-0036  yuld be filed within 72 hours al Mental Hygiene. marked other than "natural ic event, the Medical Examin		17. Fatner's Name (First, Middle, Last)  18. Mother's Name  Expanse of						
2121 uld be fi Mental I marked c event,	To Be	John Edward Kloosterman Frances  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F			te, Zip Code)			
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of				
Page ment o tant:		4 Donation 5 Other Specify: Kalas Crematory 12-	8-2008		, Maryland			
Baltimore, permit. Pages I a Department of He Important: If ite		21. Signature at Fugeral Service Licensee 22. Name and Address of Facility Geo						
Physician		2973 Solomons Isla 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	nd Rd., r respiratory arre	Edgewater est, shock, or heart	MD 21037 Approximate Interval			
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dise	ase		Between Onset and Death			
caminer		or condition resulting in death)  Due to (or as a consequence of):	501					
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	min	cause. Enter Underlying Cause (Disease or injury that initiated			1			
E Edu	Examiner	events resulting in death) Last Due to (or as a consequence of):						
executed an and al - transit	g	x UNPENDED AMENDED 23a,pt.II,27 per me g886 12-20	-08 vt		1			
760, Treate be exe g physician a	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery			
Sox 687 death certific e attending   for use as th	ian/	past 12 months?	2 Fetal death 3 Ectopic pregnancy Month Day					
30x death of	ysic	1 Yes 2 No 9 V Unknown 9 Unknown						
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?			
s, P.( ires than signed d be det	D D	Chronic Alcoholism	1 Yes	2 No 3 Pr	obably 4 V Unknown			
ords, w requir	plete		24a. Was a autop:	sy prior to	autopsy findings available completion of cause of			
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Division of Vital Records, tal or Attending Physician: The law require is after death an Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursin						
n of Viding Physical After this funeral di	5	1 Ves 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursin  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?		Residence 6  Oth	er: Scene			
Sion ( Attending death setor: Af	tion	Natural 5 Pending 1 Yes 2 No						
visior or Attend fler death Director: in by the	iţica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City			
Divis Hospital or A 24 hours after Funeral Directed filled in b	Certification:	4 Homicide determined (Specify)	or Town, S	tate)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a						
To the I within 2 To the I complet	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (M				
		Poter O.C.M.E.		December 6, 20				
	ŀ	30. Name and address of person who completed cause of death (Item 23a)						
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201	1				
St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature						
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ding Fnysicient. The la h. Affer this certificate has funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death  1 Matural  5  Pending		Othor	eath (Check only one)  Home 5 Residence 28d. Describe how								
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Attanding Frigstoen: The law requires that the beam betiticate be especied. Cellinicate be especied. Geath, especied has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial page.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year							
ite be executed iysician and ne burial-transit	icai Examiner	Sequentially list conditions, if any, leading to untilibrial to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
hysician /Medical Examiner		shock, or he if failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	REMATURITY	ac or respiratory arrest,	Approximate Interval Batween Onset and Death							
Departm Departm Importe any inju		21. Signature of Funeral Service Lic	22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901										
permit. Pages 1 and 2 should be littled within 72 hours after deal Department of Harlit and Mental Hygiens 1. Department if them 21 is marked other then "naturel", or Items any injury or other treumatic event, the Martical Examination once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec	□Removal from State Conte	of Disposition (Name of ery, crematory or other place) of Heaven Cemetery	Dec. 5,	:. Location - City or Town, State lver Spring, Marylan							
Health and tem 27 is mother treum		19a. Informant's Name/Relationship Ronni Molina/Mot		b. Mailing Address (Street and Number or F 7808 Carroll Avenue,									
should be the nd Mental H imarked off	To Be	17. Father's Name (First, Middle, Last Anthony Dion Ri	Anthony Dion Riley Ronni Catherine M										
Hygiene Hygiene ther then	Сошр	Elementary/Secondary (0-12)	College (1-4or 5+)	Never Worked	(F) A 45 A 14 A 45	N/A							
within 72 nouts atter death with the maryland then "naturel", or Items 23a or 28a-f show he Madical Examinat must be multibut at	Completed b	15. Decedent's (Specify only highest g	Education 16	a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16t	b. Kind of Business/Industry							
ous alter death with the Marylat rel', or Items 23a or 28a-f show Examinat must be mylitied at	by Funeral	11. Marital Status  1★ Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 □ Yes 2 □ No Specifyunk		Black, White, etc.  Specify: Multi-Racial							
s 23a o	ral D	7808 Carroll Av		20912	Constitution of No.	USA							
28a-1	Director	Maryland Montgo	omery Take	oma Park	10g.	Citizen of What Country?							
how		10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limi 1 ☐ Yes 2 🔯 N							
Funeral Director		None Usual Residence of Decedent	12□ M 2□ F 0	Yrs. Months Days Hours Mir		9. Birthplace (State or Forei Country) Maryland							
		Holy Cross Hosp  5. Social Security Number 6.	oital Sex 7. Age (In yrs. last b	Silver Spring		Montgomery  9. Birtholace (State or Fore							
/Medic		4a. Facility Name (If not institution, ga		4b. City, Town, or Location of Dea	1	4c. County of Death							
Physici	an	1. Decedent's Name (First, Middle, L	ON RILEY, J	'R		Day Year 3. Time of Death							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month George Edward Reeves December 8, 2008 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b City, Town, or Location of Death VA Maryland Health reci e bane Known to Physician: Reeves, George 5. Social Security Numbe Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. North Carolina 218-12-2360 May Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Exercitive must be notified at Yes 2□No Darlington Maryland | Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2205 School Road 21034 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1943-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ò Specify: White 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Drivers Education Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Everett Reeves Margaret L. Crouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. Carole Moody - Daughter 116 Francis Street Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place)
Davington Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State NDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 11,2008 Darlington, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home P.A. 123 S. Washington St. Havre de Grace, Maryland 21078 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease or compli-shock, or heart failure. List of Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) ite henal failure **Physician** Deeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 8, 2008 28 Name and address of person who completed cause of death (Item 23a) (Type, Print) XI Ustide, MD, VA Maryland Hearth Care System, Perry Point, MD 21902 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1822 Dorothy Eleanor Roberts December 6, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 😿 F AUG 10, 1921 Missouri Director 218-70-3483 87 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 141 West Thomson Drive Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Medical Examination is ust 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adelaide Roher ည Theophilus Hoover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other troonce. 111 Brown Street, Elkton, MD Beverly J. Carroll/Daughter 21921 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10, 2008 Cherry Hill. MD Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardval Inforction **Physician** Acute /Medical Due to (or as a consequence of): Examiner Coronary Art Arter+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the ceath certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Insulm Dependent Drabeter Mellitus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has bil director, page 2 st autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ieral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO December 8,2008 DOOHTTI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sutte #3 ELKTON MARYLAND DAVID GAK-EL 304-306 North Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DECEMBER 129 A M SCHULZE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours 1 M 2 □ F 009-03-9983 90 17,1918 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 ▼No Frederick Frederick Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21704 U.S.A. 5955 Ouinn Orchard Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 1941 −

If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any Injury or other traumatic event, ING M <u>once.</u> Administrative Assistant U.S. Government 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Frederick Schulze Mildred Kolb ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5955 Ouinn Orchard Rd. Frederick, Maryland 21704 Jane Schulze (Wife) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) *December* Smithsburg, Maryland Smithsburg Crematory 9, 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 17415 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1000 Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 🗌 Yes 2 No 3 Probably 4 Unknown pertension Completed fibrioka 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an certificate has be inector, page 2 sl 1 ☐Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Certification: To 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined after 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Thomas 65 C 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DV Thanson 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fredomore

**ORIGINAL** 

29c. License number

D51643

29d. Date signed (Month, Day, Year)

12.7.08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day ONNA SANZUIL 14 OPM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12804 Windbrook Drive Clinton Prince George's Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Year) 1 M 2 CXF Months Days Hours Min. 005-34-2378 Director 69 30,1939 June CANADA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Director traumatic event, the Medical Exaculture must be notified 1 ☐ Yes 2X No MD PRINCE GEORGE'\$ CLINTON 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 12804 WINDBROOK DRIVE 23a 20735 U. S. A. Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married ō 1 ☐Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed with and Mental Hygier 7 is marked other th EXAMINER MOTOR VEHICLE ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DONALD ROSS HICKEY MARIE NELLIE TOWNSEND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau PAUL A. SAN LUIS/SON 3102 EVERGREEN AVE., BALTIMORE, MD 21214 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State DECEMBER METROPOLITAN CR. ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) OLITAN CR. 114,2008 | ALEXANDRIA, VA
22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee, M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1-500 haglar disease or condition resulting in death) /Medical Due to (or is a construence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 5 Other (specify) the 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 1 TYes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation death. ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

10

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

State

Registrar

29b. Signature and title of centries

of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address

29c. License number

1756658

29d. Date signed (Month, Day, Year)

VMD 24901

nous

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day 2008 Year **Physician** Donald N. Shrader 11 1200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CUMBERLAND ALLEGANY WMHS-BRADDOCK CAMPUS | T Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Jan. 25, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 217-28-9143 76 Pennsy vania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f shov **Funeral Director** WV Mineral 1 ☐ Yes 2 No Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 RR 2, Box 473 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 X Yes 2 ☐ No 1951 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Completed by 1955 White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Electronics Specialist Utility - Gas of Health and Mental Hygie fitem 27 is marked other r other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nevin Dalton Shrader Mae Evelyn Shrader ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse RR2, Box 473, Ridgely, WV 26753 Mary Shrader 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of F Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Pk Dec. 15 08 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service Licensee 1302 National Hwy., LaVale, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMPHOMA MANITUE CEU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EPTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi nding physician and Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No cate has been signed by the a page 2 should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ZER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alida Podrymar MD Seton Cumberland 904 Drive

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

of Vital

Division

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dec 12, 2008 Nellie Sheetz 1825 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Allegany Co. Nursing & Rehab. Ctr. **Allegany** Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Aug 14, 1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 □ ¥ 220-10-4777 92 Yrs. Director Usual Residence of Decedent Allegany 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location State r than "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at Cumberland 1 TyYes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12727 Valley View Avenue 21502 USA Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0036 Specify: white ģ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home ... rages 1 and 2 should be filet.
Department of Health and Mental Hyg. Importent: If tem 27 is marked out any injury or other transcent. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Amie Feaster Ours James Ours 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 38
Rawlings 19a. Informant's Name/Relationship (Type, Print) Shirley Gross daughter MD 21557 Rawlings 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/17/2008 Cumberland MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service License 22. Name Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death that rused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on such line. 23a. Part1. Ent the dismissions, or leart fall re. Immediate Cause (Final disease or condition resulting in death) Chronice 11 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and al-transit Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe formed? 2D No 10 kindan certificate 1 Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Intursing Home 5 Residence 6 Other (Specify) 21 No 1 🗌 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dec 13, 200 A 100 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N GUPTA, M.D. 625 AVE. CUMBERLAND, MD 21502 KENT 31. Date filed (Month, Day, Year) DEC 1 8 2008 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 13,19a per fh g887 1-8-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0323 telen 12 2 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Mestern port, Mb
If Under 1 Year | f Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, (Month, Day, Allegany Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 03 23 194) **Funeral** 232744516 1 □ M 2 🔀 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Merical Examiner must be notified at WV 1 Yes 2 No Mineral Keyser Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26726 71 Maple Avenue U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) <u>Homemaker</u> <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Nick Spano MaryC. Panetta 19a. Informant's Name/Relationship (Type. Print)
Diane : Liller/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonice. 80 Chickadee Street, Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Thomas Date 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/08 |Keyser, WV 4 ☐ Donation 5 ☐ Other (Specify) Markwood Funeral Home, Inc. 21. Signature of Funeral Service Licensee ed Dec 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sindstage Immediate Cause (Final 0 Kidness **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, C the burial-tran Due to (or as a consequence of) attending physician for use as the buria Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed should be Liver cirrhosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown muttiple 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has I autopsy perform mi Uletry or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 121244 12/12/2008

Registrar
DHMH 17 Rev 1/2001

2

State

4 Broadway St., Frostburg, MD 21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jesus H. Tan, MD

DEC 1 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per verb , g886, 12/18/08dhb

Amend Item 25 per me,g886,12/16/08dhb

Certificate of Death

Reg. No. 2 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12-04-2008 James Franklin Smith **Physician** 21:25pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince georges 8. Date of Birth 12-03-1946 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 11 M 2□ F Months Days Hours 579-64-6002 62 Florida Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner ment by rediffied at once. MD Prince Georges District Heights ¥ Yes 2 □ No 10e Street and Number 6421 Pennsylvania Ave Apt. 12 10f. Zip Code 20747 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) METRO Bus Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Smith Emma Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co220743 19a. Informant's Name/Relationship (Type. Print) Shuriel Smith/ Wife 6900 Walker Mill Road Capitol Heights MD 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Cheltenhem Veteran 12-17-08 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenhem MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Dunn&Sons 5635 Eads St. NE Washington DC 21. Signature Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACTEREMI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EP515 to saptiline + # the fax to ME Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TNFSCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospitar ... within 24 hours after death.
To the Funeral Director: After managed filled in by the fur Natural Injury 1 □Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed days of death (Item 23a) (Type, Print) ourratts Rd Clinton Md 3 32. Registrar's Signature Date filed (Month, Day, Year) State 2008 **DEC 16** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#20b.c.PerFHPC12-11-08cm Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 1, 2008 Year **Physician** 10:35 A.M Roger Sylvester Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel 9. Birthplace (State or Foreign Wash., D.C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours 1070971948 Min. 1 XM 2 □ F 60 215-52-8655 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a State 28a-f shov Expr instrust by notified at 11⊈ Yes 2 No Md. P.G. Riverdale Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 6275 64th Avenue # A 20737 U.S.A. 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 2 169 - 71
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 🔀 Married Black "natural", or 1 □Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Dept. of Treasury 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Warehouseman-U.S. Customs 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Thomas E. Smith Hazel C. Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6700 Belcrest Rd.#902, Hyattsville, Md. 20782 Gwendolyn R. Smith/Wife t of Health a permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: 20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham, MD State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland veterans cem. Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 N.H. Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee shall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Renal Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et al. Carry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical the IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Cerebrovascular Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 2 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760, Hospital To the Hospital within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day, Year, DEC 0 5 2008

29b. Signature and title of certifier

29a. Certifier

(Check only one)

cal



and manner stated.

29c. License number

22966

29d. Date signed (Month, Day, Year)

December 3,2008

7300 Van Dusen Road, Laurel, Md. 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 20ປີ້ຊື່ 1:00 P M Holmes Henry Shew /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Catered Living of Ocean Pines Worcester Ocean Pines 6. Sex 1 M 2 □ F 8. Date of Birth 4/27/1915 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 93 MD 216-01-9180 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exaction of the mortified at order. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No by Funeral Director Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 77 High Sherif Trail 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2 X No Specify: Specify: white 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Western Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n/a Bessie Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 77 High Sherif Trail, Ocean Pines, MD 21811 Ronald Shew / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 12/3/2008 | Frankford, DE 4 □ Donation 5 □ Qther (Specify) 22. Name and Address of Facility Burbage Funeral Home Service License 21. Signature of Fune 108 William St., Berlin, MD 21811 June. 23a. P. 111. Enter the issease, if complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. L. t only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 □ No Day Year 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 □Yes 2 DNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27993 12-4-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA6 1001 N Philadelphia Ave., OceanCity, MD 21842 Stephen Waters 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 5 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Helen Roberta Snyder December 2008 4:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 085-24-0425 1929 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe Of. Zip Code 10g. Citizen of What Country? 11707 Kemp Mill Road 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teachers Aide Education marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file Health and Mental H tem 27 Is marked oth Be Samuel Hutt ၉ Mollie Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert S. Snyder/husband 11707 Kemp Mill Road Silver Spring, MD 20902 If item 27 or other t altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/04/08 Beltsville, MD 21. Signatury of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Dec MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart full re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Sepsis /Medical Due to (or as a consequence of): Examiner b. Ischemic Cardiomyopathy Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria the as 1 IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 24a. Was an autopsy 2 (ZNO 1 🗆 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2∐XNo Other:  $4\square$  Nursing Home  $5\square$  Residence  $6 \times Other$  (Specify) hospice1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koucetchou, md 20063748 December 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (10) 12 Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 05

32. Registrar's Signature

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	Physicia	an	Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Year	3. Time of Death
v T	/Medic	al .	SABINA 4a. Facility Name (If not institution		L-LEM		4b City Town o	Location of Deatl		1 4c. County	of Death	1319 M
1	Examin	er	176 JOYCETON				LAM			Prince	6	ever's
-	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th !		lace (State or Foreign
	Director		NONE	1 □ M 2 XF	<del>√/</del> € 75	Yrs.	Worth Bays	TIOUIS IVIIII.		'k- 1933		* *
	w .	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		-		1	0d. Inside City Limits
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	after death w or Items 23a miner must I	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	14. Race Blac	e - Americ k, White,	
20	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:		Specify	:	BLACK
⋛	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	edt	15. Deceden	t's Education	- 1	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Ind	lustry
<u>ლ</u>	within 72 ho giene. r than "natu the Medical	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	i+)	(Give life. l	kind of work done DO NOT use retired	during most of wor ii)	rking			
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and	be filk tal Hy d oth event	EIT 5 5 0 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)							•	, Maiden Surnam	e)	
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စ်	s 1 and f Health item 27 other to		20a. Method of Disposition	·	20b. Pla	ice of Dispo	sition (Name of matory or other place	1	Date	20c. Location -		wn, State
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each lin	I the death. ne.	Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
C	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Arterio	sch	erotic	Hype	ternia	e Hear	Dise	عدم	
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ب		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a conseque	ence of):						
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	£ 5	/Me	IF FEMALE:	23c. If yes, outcome	pf pregnan	cy				23d Dat	e of delive	an/
X Q	death certif attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal o	death 3	Ectopic pregnancy Other (specify)	/		Mo		Day Year
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S,	The law requires that the death certi te has been signed by the attending tage 2 should be detached for use	by P	Part II. Other significant conditi	ons contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.				ne cause of death?
g	equire en sig ould b								1 🗆	Yes 2 No	3 Prob	ably 4. Onknown
ပ္ပ	law ras be	Completed							24a. Was	psy t	prior to cor	psy findings available npletion of cause of
Vital Records,		Con							pend 1□ Yes	2 No 1		27 No
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?  1 ☑ Yes 2 ☐ No	Hospital:	0515	·D/O-44:	oth SCI DOA Oth	or:	ath (Check only			redone
ŏ	Physer this eral dil	1: 70	27. Manner of Death	1 ☐ Inpatie	ıry 2	R/Outpatier 28b. Time o	II JUDOA	4 Li Nursing r	T	how injury occurr		y)
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DIVISION	r Atte er dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   20e. Place of Inj	ury - At hom		eet, factory, office			Street and Numb	er or Rura	I Route Number,
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	Hosp 24 hou Fune tely fil	Medical		ng Physician: To the best Examiner: On the basis of	of examination							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Med	29b. Signature and title of certific	and manner st	ateu.		29c. Licens	se number		29d. Date signed	d (Month,	Day, Year)
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0	2		30. Name and address of person	who completed cause of c	leath (Item 2	23a) (Type,	Print)	,	1	_	1	1
1			30. Name and address of person  31. Date filed (Month, Day, Year,  DEC 0 5 2008	exter 300	1 Ho	SpiTa	el Drin	e da	rery,	MARY	(a,	d
Ž.	Sta Registr	ite	31. Date filed (Month, Day, Year,	32. Registr	ar's Signati	uré			-/	V		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Naomi Thompson 12 2 2008 6:20 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 115 Park Dr. Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X Days Hours 217-52-4650 75 2-23-1933 TN Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNo MD Director Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 115 Park Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: ģ White 3 Notice display 3 Notice 3 Notice 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fil Health and Mental H Im 27 is marked oth Grover Mullins Dora Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is any Injury or other trau Michelle Knutson / Daughter 115 Park Dr., Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3X Removal from State Upperville, VA 5 ☐ Other (Specify) 12-6-2008 4 □ Donation Ivv Hill Cemetery 22. Name and Ad ress of Facility Harry H. Witzke's Family F.H. 21. Signature ral Service M01411 4112 Old Columbia Pike, Ellicott City 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate L terval Between nset and Death Immediate Cause (Final disease or condition resulting in death) ypoxemia nyquence of): Physician /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a detached f 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ► No 24a. Was an page 2 s autopsy 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 300 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

86

To the I

State Registrar

Medical

29a. Certifier

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 405 Frederic Registrar's Signature Year) 32. 31. Date filed (Month, Day,

			For State Registrar	State of Mar	•	•	ment of H ficate of L			iene eg. No. 2 () ()	8 1.7435		
	Physicia	in	1. Decedent's Name <i>(First, Middle, Las</i> Linda						2. Date of Deat Month December	Day Year	3. Time of Death 12:41 p.M		
an of	/Medic Examin		4a. Facility Name (If not institution, give		5	4	b. City, Town, or	Location of Death	ресешье	4c. County of De			
1	LXuiiiii		11006 Wolfsville	e Road			Myersv	ille		Frederi	lck		
	Funeral Director		213-60-8383	ex 7. Age ☐ M 2∏ F	(In yrs. last birt		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 29	Year) (	irthplace (State or Foreign Country) aryland		
	/land low		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town	or Locat	ion				10d. Inside City Limits		
	a-fsh	ctor	Maryland Frederi	ick	Myers	svill	_e				1 □Yes 2√√ No		
	or 28%	Dire	10e. Street and Number 11006 Wolfsville F				10f. Zip Code		1	0g. Citizen of What C	Country?		
	eath w	Funeral Director		12. Was Decedent Ev	er in II S	13 Was	21773		ecify Yes or No-	USA 14. Race - Am	nerican Indian		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Extraction and the Lostified at once.	5	11. Marital Status  1 ★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:				spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	ite, etc.		
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121	within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			strator	)		ublic Sch	001		
Maryland 21215-0036	ld be filed ental Hyg <b>ked other</b> ic event, l	To Be C	17. Father's Name (First, Middle, Last) Charles Ellswort		, 22			18. Mother's Name Lucille	e (First, Middle, Mary Bo	,			
ary	shoul and M s mar	-	19a. Informant's Name/Relationship (7	Type. Print)	19b.	. Mailing A	Address (Street &	and Number or Rur	ral Route Number	, City or Town, State,	, Zip Code)		
Z,	of and 2 should be Health and Ment tem 27 is marked other traumatic e		Lisa Montgomery/	niece						yland 217			
Baltimore,	. Pages 1 tment of ⊬ tant: If ite jury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	y)	Smiths	ry, cremate burg	on (Name or ory or other place Cremato	ory Dec.1	and the second second		, Maryland		
Ball	permit Depart Import any in		21. Signatur of Funer   Servic Lensee   22. Name and Address of Facility   504 Main Street   Ricketts Funeral Home   Myersville, MD 2177										
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of beart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a  Approximate Interval Betw Onset and Do										
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0	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	of):							
16.	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence o	of):							
68760,	rificate be executed g physician and as the burial-transit	edical I	· ·	⊾d			******						
	certifica ding ph se as th		IF FEMALE:	23c. If yes, outcome of	pregnancy					Old Date of d	oliver.		
.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use i	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ ₩6 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death		ctopic pregnancy ther <i>(specify)</i>	/		23d. Date of d Month	Day Year		
ds, P.	uires that the de signed by the a d be detached f	Ď	Part II. Other significant conditions of	ontributing to death but	not resulting in	the unde	rlying cause give	en in Part I.	23e. Did tob	. /	to the cause of death?		
Co	w requir s been s should I	etec							24a. Was a	n 24b. Were a	autopsy findings available		
E E	iician: The lav certificate has ector, page 2	Completed							autops perforn 1 □ Yes 2	ned? death?	completion of cause of		
/ita	cian: ertific	BeC	25. Was case referred to medical examiner?	I I A-I			101	26. Place of Deat		· ·			
of \	Attending Physician: r death. sctor: After this certifici by the funeral director, p		1 Yes 2 No 27. Mann f Death	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Ou 28b. T	rtpatient	3 DOA Othe	4 Li Nuising no		ence 6 Other (Sp ow injury occurred	pecify)		
ion	nding P ath. :: After e funer	ation	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	<i>Year)</i> Ir	njury	Work	? Yes 2 □ No		minjary occurred			
Division of Vital Records,	al or Attend after death Director: d in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	rm, street	, factory, office		28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,		
	To the Hospital or Attending Physician: The law within 24 butous after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		nysician: To the best of niner: On the basis of and manner state	examination an								
	To th To th comp	Ĭ	29b. Signature and title of certifier				29c. License	e number		9d. Date signed (Mo			
			1 Jon	twy	M	0	125	8341		12-10-	08		
-	3		30. Name and address of person who	completed cause of dea	ath (Item 23a) (	(Type, Pri	TOUH	ouse 1	fre,	12-10- Freder	ich MD		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	and)	1				21701		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Mahlon December 13, 2008 7:15 Andrew Wynkoop 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12047 Mapleville Road Box 7 Washington Cavetown 8. Date of Birth (Month, Day, Year) Jan. 12, 19 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Hours 216-30-2814 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Washington Cavetown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12047 Mapleville Road Box 7 21720 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Packaging Services 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ross Cornelius Wynkoop Violet Catherine Randall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessie I. Wynkoop/Wife 12047 Mapleville Road Box 7, Cavetown, MD 21720 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Rest Haven Cemetery 12/17/2008 | Hagerstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mar 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

δ

Completed

Be

MD

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

bunial-tran Division or Vital Records, P.O. Box 68760 the attending p signed by the a d be detached f

To the Hospital or Attending Physician:

: After this certific funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

	shock, or heart failure. List only	one cause on each line.			Onset and Death					
	Immediate Cause (Final disease or condition resulting in death)	me 3 man								
hysician/Medical Examine	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	b								
	resulting in death) Last	c								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did to						
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9	25. Was case referred to medical		26. Place of Death (Check only one)							
0 0	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing I	Home 5 █ Resid	ence 6 □Other (Specify)					
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	28d. Describe h	now injury occurred					
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Numb City or Town, State)						
Medical (	29a. Certifier (Check only one) Certifying Pr	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investion and manner stated.	urred at the time, date and plac gation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)					
M	29b. Signature and title of certifier	1	29c. License number		29d. Date signed (Month, Day, Year)					

5

State Registrar

31. Date filed (Month, Day, DEC 1 8 2008



D46473 Dec. 15,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 10:25 A M Wilson December 11, 2008 Maggie Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1006 Potomac Ave. Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Securify Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🗓 F Director 215-36-6300 78 Feb. 26, 1930 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f show 1 TYes 2 □ No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1006 Potomac Ave. Apt. 1S 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ed other than "natural", or event, the Medical Exami þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ies 1 and 2 should be fill of Health and Mental H Be ပ Elijah E. Loveless Addie Marie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Cross/Daughter 16342 Spielman Road, Williamsport, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State cedar Lawn Mem. Park 12/16/2008 Hagerstown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or completions that caused the death. Dynet enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the death certificate be executed Exami burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 9 ☐ Unknown ed by the detached 9□Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 5 Residence 6 □Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica e Funeral I

> State Registrar

To the

Medical

29b. Signature and title of certifier

Month, Day,

29a. Certifier

**ORIGINAL** 

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

			1 - State Registrar		/larylan		artment of rtificate o				eg. No.	108	+050
	Physicia	an	Decedent's Name (First, Middle     CATHERINE	, Last)	WILI	LIAMS				Date of Deam     Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution	give street and number			4b. City, Town	or Location	of Death	DECEMB	4c. County		8:00A M
	Examin	er	2204 VIRGINIA		/		LANDO		0. 2000.		1		ORGE'S
	Funeral Director				Age (In yrs. 76	last birthday) Yrs.	If Under 1 Yea Months Day	r If Under	24 Hrs. Min.	8. Date of Birth (Month, Day JAN 7		9. Birth	place (State or Foreign ofty) INGTON, DC
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Are 71 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the healtest examiner must be notified at	Funeral Director	Usual Residence of Decedent   10a. State	NCE GEROGE		y, Town or Lo				1	0g. Citizen of W		10d. Inside City Limits 1  Yes 2 □ No ntry?
9500	nours after dea ural", or items LExaminer mi	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 [X]Divorced	12. Was Deceder Armed Forces ed 1 ☐ Yes 2,F If Yes, Give Year or Dates	s? ] No		1∐Yes 2∭XN	o <i>Specify:</i>		ecity Yes or No- Rican, etc.)	Black Specify.	k, White,	BLACK
-6171	within 72 h ene. <b>than "natu</b> re Predice	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4o	r 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti NURSE	e durina mos	st of worki		16b. Kind of Bu		dustry
Idila	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, I	· · · · · · · · · · · · · · · · · · ·		<u></u>	NORDE	1	er's Name	(First, Middle, I			
_	0 ± 1 = 0		19a. Informant's Name/Relationsh							al Route Number			
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	permit. Departimporti any inji		21. Signature of Funera Service	icens	-	22	Name and Add			J. B. JI D LANDOV			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each	line.	CANCE		ying, such as	s cardiac (	or respiratory arr	est,		Approximate Interval Between Onset and Death
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.O. DOA 00.	to the mospital or Attending Priysician: The law requires man the death certificate be executed within 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth	23c. If yes, outcome of pregnancy  1							ery Day Year	
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	lo the Hospital of Attenol within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	ledical Cer		g Physician: To the bes Examiner: On the basis and manner	st of my kno	wledge, deatl	n occurred at the	time, date a		and due to the c	ause(s) and ma		
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2	3		30. Name and address of person v	·		, , , , ,	Print)	··			RYLAND 2	2078	
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State Registrar

DEC 0 5 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Amend#29d. PerPhys. PCC12-5-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Jinyun Wang November 26, 2008 7:20p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Village Health Care Ctr. Montgomery Village If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 7, 1938 Peo. Rep./ China **Funeral** 1**™** M 2□ F 216-65-4156 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: It flem 21 is marked other than "ratural", or items 23a or 28a-f shoi Important: If them 21 is marked other than "ratural", or items 23a or 28a-f shoi any injury or other traumatic event, the "Modical Examiner must be notified at 14 Yes 2 □ No Director Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 Peoples Rep. of China 38 Timber Rock Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Chinese Specify: 2 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Government s 1 and 2 should be filed w if Health and Mental Hygie tem 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mingde Shutang Jin Wang ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 38 Timber Rock Rd. Gaithersburg, Md. Bing Wang / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan/ Crematory 12/6/2008 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Alexander S. Pope / P.A. 5538 Mariboro Pikė/Forestville, Md. 0.401055 23a. Part / Enl. r the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequ P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 ☐ Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 🗆 No 1 □ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this funeral 27. Manner of Death 1 XNatural 2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. neral Director: A filled in by the fu 1 ☐ Yes 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

within 24 hours a State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahamed Hesmat MD

29d. Date signed (Month Day 22008

19301 Watkins Mills Rd. Montgomery Village, Md. 20886

170021210

31. Date filed (Month, Day, Year) DEC 0 5 2008

certifier

(Check only one)

29b. Signature

and manner stated

Registrar

08-08897 Lonnie Wade, IV

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ie Wade, IV		State of Maryland / Department of Health and Mental F	Hygiene		
ile vvade, iv		For State Certificate of Death		Reg. No.	3. Time of Death
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Examine	er	60nnie Wade IV  (foot heritution give street and number)  4b. City, Town, or Location of Dea		4c. County	y of Death
, )	4	Prince Georges Hospital Center  4b. City, Town, or Location of Dea		Prince	George's
		7. Age (In yrs. last birthday) If Under 1 Year If Under 24H			YY) 9. Birthplace (State or Foreign
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any		10a. State 10b. County 10c. City, Town or Location			1 X Yes 2 No
<u>*</u> .	_	MD Prince Georges Clinton		10g. Citizen of	
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or ite	핅	1 Yes 2 No No specify:	•	Specif	s: Black
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2121 ould be fill Mental !!	Be	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number)	r or Rural Route	Number, City or	Town, State, Zip Code)
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Balti permit. Departi Import injury		July // 7908-B (B) mg	Canno liac or respirator	ry arrest, shock, o	orton VA zzo79 or heart   Approximate Interval
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Dospita hours ineral	S	298. Certified A Continue Physician: To the pest of my knowledge, death occurred at the	ice, and due to t	the cause(s) and r	manner as stated.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the after commelee, Filled in by the funeral director, page 2 should be deadfied for u	1 3	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death osc	curred at the tim		
To T		29c. License number		29d. Da	ite signed (Month, Day, Year)
	1	Man Bross (M)		Nove	mber 27, 2008
0 2	1	30. Name and address of person who completed cause of death (Item 23a)  Maliaca Brassell MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e MD 2120	1	
R 3		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore			
	Sta				
Regi	eili	DEO O J LOVE DE LA COMPANIE DE LA CO			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 5:05 aM Laskar A. Wechsler December 01 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rethesda Eden Home Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 X M 2 □ F August 29, 1918 New York 098-05-6654 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ka Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Cumbernauld Court 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 夏 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Mechanical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Schwartz Charles Wechsler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Stein - Daughter 7 Cumbernauld Court, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/04/2008 4 Dopation 5 Dother (Specify) Fort Lincoln Crematory Brentwood, Maryland of Funeral Service Lig 22. Name and Address of Facility 21. Signature Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the Jist ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the usering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 K No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 8 \( \text{K} \) Other (Specify) 4 \( \text{Living} \) Hospital: 1 ☐ Yes 2K No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner Physician: The law requires that the death certificate be executed burial-transi and attending physician for use as the buria Box 68760. P.0. ed by the a signed t Division of Vital Records, cate has been si page 2 should t certificate director, this After or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. the filled in by completely

**Physician** 

/Medical

Examiner

**Funeral** 

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Certification:

Medical

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evanther must be notified at

72 hours after

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic avent

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 4 2008

D26259

December 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 1340 Glen Albert Webb 8005 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. July 4,1924 . Virginia **Director** 84 West 218-16-4121 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It will also in a marked traumatic and injury or other traumatic event, It will also in the mount of the marked and injury or other traumatic event, It will also in the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of the mount of th 1∐Yes 2∭XNo Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 1707 Mt. Aetna Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Brakeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Staniforth Webb Nile Webb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Mt. Aetna Rd. Hagerstown, MD 21742 Jane D. Webb-wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 12-11-2008 | Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee <u>Fastern Blvd. North Hagerstown</u>, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause Final ploat **Physician** disease or condition resulting in death) /Medical Examiner puene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-trai resulting in death) Last coronary Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) the 1 ☐Yes 2 ☐No detached 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Rua 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate elli 1 □Yes\_ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Box 68760. P.0. Records, of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division

altimore, Maryland 21215-0036

State Registrar

31. Date filed (Month

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Herbert Car1 Yablon 12:00 p<sup>M</sup> November 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph's Home Assisted Living Center 8. Date of Birth (Month, Day, Year) Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F 200-22-7401 Director 1931 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventher must be redified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12515 Barbara Road 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ Specify: 3 Widowed 4 Divorced Year or Dates Korean Conflict White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 ntal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 Is marked other th 4 Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Simon Yablon Hannah Hess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 12515 Barbara Road; Silver Spring, MD 20906 Judith Yablon / Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/04/2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter he diseas shock, or reart failure , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line, Immediate Cause (Final disease or condition resulting in death) **Physician** a. Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of) the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: f yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 DUnknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure, Anemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate the completely filled in by the funeral director, page 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Assisted 1⊠ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42518 12/02/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike #401; Rockville, MD 20852 Gul Chablani, M.D. 31. Date filed (Month, Day, Year) DEC 0 4 2008 Registrar

			For State Registrar	State of	Marylan		artment of F		d Mental Hy	giene Reg. No. 200	3 40545
	Physici /Medio		1. Decedent's Name (First, Middle, La EARL ILOUIS	S Z	EPP	JR.			2. Date of De Month DECEMB	Day Year	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, given FREDERICK MEMORE)  5. Social Security Number 6. 8	RIAL HOSP	TTAL Age (In yrs.	last birthday)	4b. City, Town, or FREDERI If Under 1 Year Months Days		rs. 8. Date of Birt	4c. County of Dea	CK rtholace (State or Foreign
	Director		261-47-9831  Usual Residence of Decedent  10a. State 10b. County	1⊠M 2□F	60	Yrs. y, Town or Lo		TIOUIS IVII	Septem	ber 7,194	Marylan  10d. Inside City Limits
	th the Mary or 28a-f sh	Director	Maryland FRE  10e. Street and Number	DERICK		FRED	ERICK 10f. Zip Code			10g. Citizen of What C	1 X Yes 2 □ No
036	be filed within 72 hours after death with the Maryland that Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Expriding must be notified at	by Funeral	117 APPLE CRE  11. Marital Status  1	EK ROAD  12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? [ <b>X</b> No	I .		702 ispanic Origin? in, Mexican, Pur Specity:	(Specify Yes or No erto Rican, etc.)		erican Indian,
Baltimore, Maryland 21215-0036	filed within 72 hou Hygiene. Ither than "natura ent, tre Medien E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) N/A	ducation ade completed) College (1-40	or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired N/A	during most of w	vorking	16b. Kind of Business	s/Industry
aryland	should be file and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last  Earl Louis  19a. Informant's Name/Relationship (	s Zepr	o Sr		ng Address (Street	Mar	,	Maiden Sumame) Cguerite er, City or Town, State,	Sheehan Zip Code)
nore, Ma	permit. Pages 1 and 2 should be Department of Health and Mentic Important: If Item 27 is marked any injury or other traumatic evonce.		Carmen W. Bundio	Removal from Sta	ue i	433 Place of Disponentery, crem	Brewer (Name of patory or other place	Avenue,	Hagersto Date	Wn, Marylar 20c. Location - City or	nd 21740
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1	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Car		n. Do not ente	er the mode of dyin	g, such as card	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed by yesician and the burial-transit	dical Examiner	Sequentially list conditions, it is a property to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequ	onia					days
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No  27. Manner of Death 1 X Natural 5 ☐ Pending investigation	28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 🗆 Nursing		ne) ence 6  □Other (Spe ow injury occurred	ecify)
Divis	ital or Atte irs after de ral Directo	Certific	3 ☐ Suicide 6 ☐ Could not be determined	building,	etc. (Specify	v) 	et, factory, office		City or Tow		
	the Hosp hin 24 hou the Fune mpletely fil	Medical	(Check only 2   Medical Exar	nysician: To the be miner: On the basi and manner	s of examina	wledge, death tion and/or inv	estigation, in my o	oinion, death oc	curred at the time, o	cause(s) and manner a date and place, and due	e to the cause(s)
	<b>7</b> with		29b. Signature and title of certifier  R. Rerge	<u> </u>				65835		29d. Date signed (Mont	
V1	H-3		Rohan R. Reng	jen, 4	00 W.	&th	*	Frede	erick, M	aryland 2	21701
	Sta Registr	. I	31. Date filed (Month, Day, Year)  DEC 0 9 2	008	strar's Signat	ure A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death dent's Name (First, Middle, Last) **Physician** 2, 2008 ar:or /Medical Town or Location of Death County of Death not institution, give street and number, Examiner ltimore atons ville lanox **Funeral** 1□ M 2**X**F Months Days Hours Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maxical Experiment of the resident 1 ☐Yes 2 No Director toward 10g. Citizen of What Country? 10f. Zip Code Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Bla Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DONOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n; dary (0-12) College (1-4or 5+) oer Uison 's Name (First, Middle, Maiden Surname, 17. Father's Name (First Middle, Last) Be 085ie မ permit. Pages 1 and 2
Department of Health a
Important If item 27 is
my injury or other tra 3216 Vouds ormand 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part I. Enter the insease, or complications that caused the death. Do not enter the mode of dying, shock, or heat silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of), Examine requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 □Yes ②⊠No Day Month Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed by ti d be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pagr 1 ☐ Yes 2 ☐ No 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Ox Other (Specify) Assur fu 1 Tes 2 HNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Emman Ham march 31. Date filed (Month, 32. Registrar's Signature State Registrar

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Ĕ	nit. Page: artment o ortant: If injury or		4 □ Donation 5 □ Other (Specify)	Arde	ent Cre	mation	Serv	iœ   l	12/19	/2008	На	nover	, Ma	ryland
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee			. Name an			ALC					ices, LLC MD 21076
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death.									-	Approximate Interval Between
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<u>&gt;</u>	or A after Direct	erti	4 Homicide determined 28e. Place of Injurious	c. (Specify)	o, rarri, ouc	ot, idotory,	onico			City or To	wn, St	ate)	or or rian	arriodie ramber,
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	00		30. Name and address of person who completed cause of c	leath (Item 2	3a) (Tvne F	Print)	<del>-</del>	, 110	70			, ,	-	
	,/	to	TIPAPORA CUCCOCLARD, MD. E	5330	WISCUM		AV	\$ 55	50 (	CNENG	CH	USP,	MD	20815
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		For State Registrar	State	of Mary	land / Depa <i>Ce</i>	artment of rtificate o				giene 2 ()	08	40540
		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea		.,	3. Time of Death
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/Med Exami		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location	on of Death	рессии	4c. County		1.20 A
Exami	ilei	15 Margaret Ave	-	,		Pasade						ndol Co
Funeval		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Yea		er 24 Hrs.	8. Date of Birth	1		ndel Co place (State or Foreign
Funeral Director		212-44-5099	1☑ M 2□ F	64	Yrs.	Months Day	s Hour	s Min.	(Month, Day	(Year)		place (State or Foreign ntry)
		Usual Residence of Decedent		04					March 1	3,1944	Ma	ryland
and		10a. State 10b. County		100	c. City, Town or Lo	cation		-		-		10d. Inside City Limits
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ath v s 23e	Funeral Director											
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IVIC Ind 2 Ith a 27 is		Shirley Adams	sp	ouse	15 1	Margaret	Ave.	Pasa	dena MD	21122		•
Hea Hea		20a. Method of Disposition		2					Date	20c. Location	- City or T	own. State
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To the Hospital or Attending Physician: The law requires that the death certification is the hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one)	and ma	nner stated.								
Neith Con To To To To To To To To To To To To To	Σ	29b. Signature and title of certifie	r			29c. Lice	nse numbe	er	2	9d. Date signe	d (Month,	Day, Year)
		11/66	- Mo	)		D006	53270			Decembe	r 16	,2008
3+1		30. Name and address of person	who completed cau	use of death	(Item 23a) (Type	Print)						
7			Robertson				uite	211 M	illersvi	11a MD	2110	18
C+	ate	31. Date filed (Month, Day, Year)		Registrar's S		2.6						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09392 State of Maryland / Department of Health and Mental Hygiene Ronald Bryant Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Physician/ Month Day December 14, 2008 1034 hrs Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours Min 03/1965 Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Yes 2 No 23a or 28a-f show notified at once. MD riends Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Numbe 12426 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiène. Funeral Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces Never Married Yes 2X No specify: Specify: If Yes. Give Year Yes Divorced Widowed traumatic event, the Medical Examine ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 If item 27 is marked other than Father's Name (First, Middle, Last Be 19b. Mailing Address MD Baltimore, MD enne 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Marriottsville, m crematory or other place Removal from State X Burial 2 Cremation 12.20.08 Donation 5 Other Specify: hature of Foneral Service Licens 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. m Approximate Interval Between Onset and **Physician** Death /Mucical Cardiac tamponade Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Aortic dissection Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed AMENDED PI line a-b,27,perME, g886 12/23/08 TT and Physician/Medical X UNPENDED attending physician or use as the burial Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown detached 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö Yes 2 No 3 Probably 4 Vunknown ģ Records, P. Completed 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? After this certificate has funeral director, page 2 sh performed' 1 V Yes Nο ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 Residence 6 Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 1 🗸 Yes Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death To the Hospital or Attending within 24 hours after death 1 X Natural Yes 2 No Pending To the Funeral Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Windical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 15, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) egistrar's Signat 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1555 M December 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner SALTIMORE AGNES HESPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Director and Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director xa Hamore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21225 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be 1 ပ William Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 56n 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State saltimore, 21. Signature of Funeral Service Licensee Name and Address of Facility Balto. MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 25 days Embolic Immediate Cause (Final disease or condition resulting in death) arcli in Brain Physician ple /Medical Due to (or as a cor sequence of): **Examiner** al Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of) Physician/Medical Box If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery that the death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) □Yes P.0. by the 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ requires 1X Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 2 No Vital 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this ot 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ဂ္ 2349 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST AGNES HEALT HEALT ME - 21 ADHIKA AVENUE, NANDI 900 CATON

State Registrar 31. Date filed (Month, Day, Year) DEC 1 9 2008

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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20Ö8 December 12:55 a <sup>M</sup> Richard McCulloch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Fairfield Drive Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, SEP 7 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 212-05-4712 95 1913 Minnesota Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f showevent, the Medical Experience must be notified at Director 1 ☐ Yes 2X No MD Baltimore Catonsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 3 Fairfield Drive 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any linky or other traumatic event, the MAJ once. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Utilities 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Maxwell Cunningham Byers Janet McCulloch ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet Byers - niece 1228 Cedarcroft Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/18/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DAYS Aroses /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b Signature and title 29d. Date signed (Month, Day, Year) A HENDING 7118 2008 Name and address or person who completed cause of death (Item 23a) (Type, Print) M.D. 3512 21218 SchwARTZ 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 19 2008 Registrar

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**DECEMBER 17, 2008** 

	Division of Vital Records, P.O. Box
	To the Hospital or Attending Physician: The law requires that the death cert
١	within 24 hours after death.
\	To the Funeral Director: After this certificate has been signed by the attendin
	completely filled in by the funeral director name 2 chould be detached for use

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			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
	Physicia		Ronald Lee Bates					Decembe	r 17, 2008	10:55 A <sup>M</sup>		
	/Medic Examin	-	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		4c. County of Death			
		-	Stella Maris Hospi			Timon		T	Baltimore			
	Funeral		5. Social Security Number 6. Sex		57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 28,	1951 Nort	place (State or Foreign ntry) Carolina		
	Director		Usual Residence of Decedent		37			rai 20,	IJJI NOLU	ii caroriia		
	/fand iow		10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits		
	a-f st	ctor	Maryland Anne Arunde	1	Brookl	yn				1 □Yes 2 ☒ No		
	or 28	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cou	ntry?		
	ath wi	ra	417 Holy Cross Road			21225		- '' . V N	USA			
	er dez	Funeral	11. Marital Status	as Decedent Ever in med Forces? Yes 2 XNo	U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,			
5	rs afte	by F	If \	res 2[ <b>X</b> NO res, Give ar or Dates:		1 □ Yes 2 XTNo	Specify:		Specify: Wh	ite		
3	should be filed within 72 hours after death with the Maryland Ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Examinar must be notified at		15. Decedent's Education		16a. Dece	dent's Usual Occupa	ation	dna	16b. Kind of Business/Ir	dustry		
2	hin 7, e. an "n Medi	Completed	(Specify only highest grade come Elementary/Secondary (0-12)	ollege (1-4or 5+)	ilife. I	kind of work done d DO NOT use retired;	)	ung	Heenitel			
7	ed wit	S	11		Medic	al Billin		(5) 1 14:11: 4	Hospital			
2	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e ( <i>First, Middie, R</i> Chipman	valuen Surname)			
7	d Mer narke	ပ္	Robert Lee Bates  19a. Informant's Name/Relationship (Type. Pr	:_4\	10b Mailir	an Address (Street s			; City or Town, State, Zi	n Cade)		
2	d 2 sh th an th an traur		Patricia E. Conticel						and 21286	0 0000/		
ນົ	Heal Heal tem 2		20a. Method of Disposition			sition (Name of matory or other place			20c. Location - City or T	own, State		
2	Pages ent of nt; If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)			ematory I		8/08	Baltimore,	Maryland		
Dallillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be routified at once.		21. Signature of Funeral Service Liconsee	~	2	2. Name and Addres	Society	Of Marvl	and, Inc.	A 21228		
_	402 60		Thomas Gregor	s that caused the de					re, Marylar	Approximate		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final				0.			Interval Between Onset and Death		
1	Physician /Medical		disease or condition	RENAL CANC Due to (or as a cons								
	Examiner											
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):							
/	ecute and trans	Examiner	that initiated events c	Due to (or as a cons	anuonee eft.							
8/00,	ficate be executed physician and s the burial-transit	a E		Due to (o) as a cons	equence on.							
20	ficate phys s the	edical	d									
X O O	that the death certific led by the attending p detached for use as i	Physician/M	IF FEMALE: 23c. If	yes, outcome of preg	gnancy	□ Cataria programano			23d. Date of deli	,		
ם מ	death re atte	icia	in the past 12 months?	☐ Live birth 2☐ Fo ☐ Pregnant at time o ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)	y 		Month	Day Year		
7. 5	at the by the	hys	9 ∐ Unknown				and Death	O2a Did to	bacco use contribute to	the gauge of death?		
Š,	w requires that the desires should be detached	ρ	Part II. Other significant conditions contribut	ing to death but not r	esulting in the u	ngeriying cause give	en in Part I.		es 2 No 3 Pro			
cords	law requires as been sign 2 should be	sted				· · · · · · · · · · · · · · · · · · ·						
ည	2 38 29	Completed					<del></del>	24a. Was a autops perfori	sy prior to c	opsy findings available ompletion of cause of		
Iga	n: The l ficate har, r, page		OF Manager referred to modified			_	00 Disease f Date		2 <b>X</b> No 1 ☐ Yes	2 No		
>	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2	□ EB/Outnatie	nt 3 DOA Othe		th (Check only on	ence 6 <b>X</b> Other <i>(Spe</i> c	(fv) HOSPICE		
0	<b>50</b> 0 0	n: To	27. Manner of Death 28	a. Date of Injury (Month, Day, Year	28b. Time o			·	ow injury occurred	,,		
VISION	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Worth, Day, roan,	,,,		Yes 2 □No					
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - A building, etc. (Spe	t home, farm, st ec <i>ify)</i>	reet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,		
5	bours and hours		29a. Certifier 1 Certifying Physicial (Check only 2 Medical Examiner:	n: To the best of my	knowledge, dea	th occurred at the tir	me, date and place	e, and due to the d	cause(s) and manner as	stated.		
	the Hin 24 the Fi	ledical	one) X Nurse Practit	toner stated.	auon and/or n				29d. Date signed (Month			
	Nith To	Σ	29b. Signature and title of certifier	10		29c. Licens	4 / Q 7	2	.su. Date signed (Month	, Day, Teal)		
•			MANUSUA	1	thom Ode /To	1/4°	1110		141110	0		
	\		30. Name and address of person who comple	ted cause of death (I			TIMONIUM	MD 210	0.3			
į	Sta	ate	31. Date filed (Month, Day, Year)	32 Benistrar's Sig	nnature 4	-	THOUTON	, FW Z10				
	Regist		DEC 1 9 2008	the man.	A Ap	order						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** A M Dec. С. Bisser 16. 2008 5:20 Isabel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2**K** F Yrs. Dec. 21, 1917 South Carolina Director 90 251-07-0406 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment author paths any injury or other traumatic event, the Medical Experiment author paths and once. 1 ☐ Yes 2XXNo Director Lhite Hall Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 2873 Troyer Road 21161 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify þ 3 ☐Widowed 4 ☐ Divorced Lhite Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Lhite** John C. Maude ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2873 Troyer Road White Hall Maryland 21161 <u>Cynthia Buckheit/Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/17/08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroselevotic Cardiovascular Disease mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the attending physician and it be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 21250 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 1 ☐Yes 2 ☐No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2. 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1⊌ Natural 5 Pending investigation nours after death. neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD, M.D.2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 9 2008 Registrar

08-09457 Phyllis Berman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 40654

	1- For State Registrar	Certificate	of Death	Reg. No.	
Physician Medical Examine	1. Decedent's Name (First, Middle,Last) PHYLLIS		MAN	2. Date of Death Month Day Year December 16, 2008	00211118
)	4a. Facility Name (if not institution, give stree 6 Raindrop Circle	et and number)	4b. City, Town, or Location of Death Reisterstown	Baltimore	e County
Funeral Director	5. Social Security Number 6. Sex 214-44-3007 1 M	7. Age (In yrs. last birthday	If Under 1 Year If Under 24Hr  Months Days Hours Min	_	9. Birthplace (State or Foreign Country)
id how any ee.	Usual Residence of Decedent 10a. State 10b. County  FL BROWARD	10c. City, Town or Lo			10d. Inside City Limits 1 Yes 2 X No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number 8870 WOODSIDE COU	RT	10f. Zip Code 33328	10g. Citizen of Wh	•
d) + 1	1 Never Married 2 Married 1	Armed Forces? Yes 2 X No	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puert  Yes 2 X No specify:		- American Indian, Black, e, etc. WHITE
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours afthorn of Health and Mental Hygiene. Intent of Health and Mental Hygiene or other traumatic event, the Medical Examine.	15. Decedent's Education (Specify only high	hest grade completed) 16a. Dece durin	dent's Usual Occupation (Give kind of g most of working life. DO NOT use re  ISTERED NURSE	tired)	siness/Industry
215-0036 be filed within 77 mal Hygiene. rked other than ent, the Medical	17. Father's Name (First, Middle, Last) MILTON	LAVENSTEIN	18.Mother's Nam	e (First, Middle, Maiden Surname DVO	RINE
MD 2121 dd 2 should be f lith and Mental nn 27 is markee aumatic event,	19a. Informant's Name/Relationship (Type, MARILYN PETRY / SIS	STER 921	3 CRANFORD DRIVE,	POTOMAC, MD 2	
Baltimore, MD 21216 permit. Pages 1 and 2 should be fil Department of Health and Mental F important: If item 27 is marked injury or other traumatic event, t	20a. Method of Disposition  1 Burial 2 Cremation 3 X R  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	emoval from State STAR_0F	position (Name of cemetery, or other place)  DAVID CEMETERY 12  12. Name and Address of Facility	/18/2008 NORTH	LAUDERDALE, FL
Physician	23a. Part I. Enter the disease, or complication failure. List only one cause on each lir	ons that caused the death. Do not en	SOUU DEICLEDC	TOWN DOAD - DIKE	& BROS., INC.  SVIIIF MD 212  art Approximate Interval Between Onset and
/Medical examiner	Immediate Cause (Final disease a. H	ypertensive ather	osclerotic cardio	vascular diseas	e Death
sit q	cause. Enter Underlying Cause	o (or as a consequence of):			
execuin and	d.	<sub>lENDED</sub> 23a,27,perMI	E,g887 1/6/09 TT		
	E IF FEMALE:	Bc. If yes, outcome of pregnancy Live birth Pregnant at time of death Unknown	Fetal death 3 Ectopic preg Other (Specify)	nancy 23d. Date of Month	f delivery Day Year
, P.O. Box 68 res that the death certifus isgned by the attending be detached for use as	20	tributing to death but not resulting in	the underlying cause given in Part I.	1 Yes 2 No 3	ribute to the cause of death?  Probably 4  Unknown
Division of Vital Records, P.O. Box 68 is a sher death certify as ther death.  In or Attending Physician: The law requires that the death certify as ther death.  In Director: After this certificate has been signed by the attending the lineral director, page 2 should be detached for use as	Completed			autopsy	Were autopsy findings available prior to completion of cause of death?  Yes 2 No
al Finan: Trans. Ctor, 1	25. Was case referred to medical		26.Place of Death (Chec		-
of Vit ing Physic After this of	O 1 Yes 2 No	I inpatient 2 Erooups	tient 3 DOA Other, Nurse of Injury 28c. Injury at Work?	28d. Describe how injury occur	✔ Other: Scene red
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificonpletely filled in by the funeral director.	1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, (Specify)		28f. Location (Street and Numb or Town, State)	per or Rural Route Number, City
o the Hospi ithin 24 hou o the Funer	(Check only one) 2 Medical Examiner:On	To the best of my knowledge, death the basis of examination and/or invelopment stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	d at the time, date and place, and o	due to the cause(s)
- × - × - × - × - × - × - × - × - × - ×	29b. Signature and title of certifier		29c. License number O.C.M.E.	29d. Date sign December	ned (Month, Day, Year)
A bay		111 Pe	nn Street, Baltimore, MD 212	01	
Sta	20 1 1 200	32. Registrar's Signature	Sant J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤎 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:00 PM 2008 Avlyn Dodd Conley ecember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MURE Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🗓 F 84 Director 513-16-6536 Nov 15, Kansas Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Event incomes the notified at 1 ☐ Yes 2√ No Director Baltimore Catonsville 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 715 Maiden Choice Lane CR310 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Maud Winfield Darnell William Therett Dodd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD St. Agnes Hospital Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signat of Fineral Service Conal 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) **Physician** Vasular Arterioselerotic Known Coronary /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1∐Yes 2. No 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

 $\mathcal{CONLEY}$   $\mathcal{HUU}_{\mathcal{U}}$  Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: 24 hours within 2 To the

> State Registrar

Year DEC 19

Bergern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,



29c. License number

29d, Date signed (Month, Day, Year)

Denve Baltimore

# **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Experiment, as the notified at once. Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Certification: To Be Completed 24a. Was an autopsy performed? Yes 2:1 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: A 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) mayen 568 null 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Carville Litchfield Collins December 17, 2008 12:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner | Washington | Year) | 9. Birthplace (State or Foreign | Country) | MD Ravenwood Lutheran Village Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days MD 216-05-1426 89 Yrs March 20 1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State MD Washington Hagerstown 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19800 Tranquility Circle 21742 **IISA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Yes 2 No If Yes, Given Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chemicals chemical salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph F. Collins Adele M. Litchfield ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan A. Conway (daughter) 11430 Valleywood Dr., Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12-19-08 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel 1 Day Hargh erbent P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mally Canel 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** osephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore timore Genesis (ommons Cour 8. Date of Birth (Month, Day, Year) OCT. 5, 1923 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 217-14-0113 85 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at Director Yes 2□No N/A BALTIMORE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ō 103 N. CURLEY ST 21224 USA Funeral items 23a · death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the M once. UNKNOWN HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH MAY MARY BARANOWSKI ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 E. TIMONIUM RD TIMONIUM, MD 21093 19a. Informant's Name/Relationship (Type. Print) CAROLYN SANDLER-DAUGHTER 318 E. TIMONIUM RD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS CEM. 12/18/08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, of beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any made to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Ne 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy perform 1 Yes 2/4 ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Description 4 Description American Amer 1 Yes 2 N P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

of death (Item 23a) (Type, Print)

32. Registrat's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS.G\*8/, I/23/09, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 558 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec . 125, 2008 **Dorothy Miriam Carani** 7:35 A<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1 □ M 2 X F Months Days 212-24-0678 81 Apr 6, 1927 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11625 Masters Run 21042 U.S.A 12. Was Decedent Ever in U.S. Armed Forces! 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2. If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Own Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Meyers **Dorothy Coffmann** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois A. Carani 11625 Masters Run Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 20, 2008 Columbia Memorial Park Clarksville, Maryland aure of Funeral , ervice Licer 22. Name and Address of Facility MDIZOP Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardupulmona disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onchia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 9 Unknown 9 Unknown

/Medical Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, it s Medical Examinar must be multified at

permit. Pages 1 and 2 should be filed wi.
Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmaster.

**Physician** 

physician

the attending p

signed by the a

page 2 s certificate

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

lical	•	d	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
ρ		ontributing to death but not resulting in the underlying cause given in Part I.  US POST RESECTION	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Completed	Malputritio		24a. Was an autopsy performed 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
Certification: To	27. Mann of Death  1   Matural   5   Pending   2   Accident   Investigation	(Month, Day, Year) Injury Work?  M 1 □ Yes 2 □ No	3d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier 1 ♥ Certifying Ph (Check only one) 2 ■ Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

29c. License number

120064100

29d. Date signed (Month, Day, Year)

State Registrar

Bhikka 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

500 Registrar's Signature

TOCRES

M.D.

Betty Criner 08-08824 Please Type or Rint in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK aryland / Department of Health and Menta 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Day Year November 24, 2008 Medical Examiner 0940 hrs Betty Jo Criner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 9026 Pulaski Highway Middle River 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Unk If Under 1 Year If Under 24Hrs. 5. Social Security Numberunk 6. Sex 7. Age (In vrs. last birthday **Funeral** Country) Min Months Days Hours Director Nov 6, 1961  $_2$   $X_F$ М Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Baltimore Essex MD 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21221 USA 1622 B Darford Road 238 Funeral unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  $_{\rm No}$ unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Married Yes Yes 2X No specify: white Widowed 4 Divorced f Yes, Give Year Specify þ unk 16a. Decedent's Usual Occupation (Give kind of work dor  $\ln k$ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha unk unk unk iink 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in/state 21. Signalure of Luneral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Difector Baltimore MD 21201

I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failule. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 23a,PII,2/, per ME g886 12/23/08 TT X UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Invasive adenocarcinoma of the lung Completed 24a. Was an 24b. Were autopsy findings available Chronic obstructive pulmonary disease autopsy prior to completion of cause of has l performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other; DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 ✔ Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural e Funeral Director: A Pending Yes 2 No 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. November 25, 2008 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 9:30 AM M 15, 2008 Dorothy V. Corsa December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1 ☐ M 2 🔯 F Maryland Sept 85 1923 Director 216-12-6213 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Experiment must be published at once. 1√2 Yes 2 □ No MD Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21205 1042 Iris Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White à 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housekeeper/cook rectory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Hoffman Addie louise Kolb မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Jordan/daughter 861 Margo Court Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐ Other (Specify) Signature of Funeral Arviv 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execute After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Donotly ('olsh Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifie 29d. Date signed (Mpnth, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
DEC 1 9 Registrar's Signature State 2008 Registrar

15,0008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Caselanc 4:26 PM MOLLIGH Decomber 8 ZOOY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randall, town, NOAHWAIT HOSDITA Moryland Boy Himore Social Security Number If Under 1 Year 8. Date of (Month. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F Ĩ934 19, 219-92-1367 74 Apr Director Usual Residence of Decedent 10c. Cify, Town or Location 10a. State 10d. Inside City Limits a or 28a-f show be notified at 10b. County 1 Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with anent of Health and Mental Hygiene. The filed T is marked other than "natural", or items 23a or riems 23a or riems to the riems to the real marked other than "natural", or other traumatic event, the Medical Examiner must be runy or other traumatic event, the Medical Examiner must be real. 21215 2525 W. Belvedere Avenue USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married black Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un unki 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5401 Old Court Road Randallstown, MD 21133 Northwest Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 X Other (Specify) in state 21. Signature Funeral Service Licensee Ronald S. Wad State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Status Epileoticus LwK /Medical Due to (or as a consequence of) Examiner weel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last west Heart burial-tran Due to (or as a consequence of nding physician Physician/Medical Years IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Hop icani been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 2 1 N 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

29a. Certifier 1 X Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only one) eer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D67620 December 8, 200r MD

> 5401 old court Road Randallstown

Maryland

State

Rupesh 31. Date filed (Month, Day,

MD 32. Registrar's Signature

DEC 19 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 25 Month Year COHEN REUBEN 2008 December 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bal 71 MOre Hospi Fal Randallstown WEST Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X**] M 2□ F Months Days Hours 88 June 13. New York 021-16-4647 1920 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 X No Baltimore Owings Mills Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 8928 Groffs Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Nes 2 No 1942 14. Race - American Indian, Black, White, etc. 1 **X**es 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🗓 No Specify. Specify: White 1955 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Bloom Max Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8928 Groffs Mill Road Owings Mills, MD 21117 Claudia Cohen, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Metro Crematory Inc. 12/16/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Cremation Society Of Maryland, Inc. 200 Frederick Road Baltim<u>ore, Maryla</u>nd 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, II w Med gonce.

**Physician** 

Examiner

**Funeral** 

Director

show

or items 23a

death with

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mast be modified at

/Medical

10a State

Director

Funeral

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Completed

Be

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Examine Physician/Medical Completed

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and burial-tran attending physician for use as the burial signed by t I be detach page 2 s Be Certification: To After this funeral of filled in by

1 ☐ Yes 2 ☑ No

examiner'

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 🗌 Homicide

29a, Certifier

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be

9

autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ➡No

26. Place of Death (Check only one) Other: 4 \(\text{\subset}\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 4 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

December, 15, 2008

5401 Old Court Road, Randalls Town, HD 21133

31. Date filed (Month, Day, Year) DEC 1

32. Registrar's Signature



the To the within 7 Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40663 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day December 13, 2008 **Physician** Eloise K. Crowley 02:CO AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Severna Park Center Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🛛 F Director July 9, 1926 Maryland 220-12-7767 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No **Funeral Director** Maryland Anne Arundel Millersville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 8188 Northway Drive 21108 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2∏No Specify: Specify: White <u>Ş</u> 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Server Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick P. Dunsing ျှ Minnie Schatz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roma Faber - Sister 8188 Northway Drive, Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 12/15/2008 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 8000 Harford Road, Parkville, Maryland 21234 23a. Part 1. Ener my disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCHEMIC CARDIO MYOPATHY **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examine if any leading to transcript cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Be Completed 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, within 24 hours after death To the Funeral Director;

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1

Wallace (MO)

MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLACE

🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

()31136

9005 KILBRIDE RD, BALTIMORE, and 21236

29d. Date signed (Month, Day, Year)

DECEMBER 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29a perDVR, G886, 12 / 19 / 08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 12, 2008 **Physician** 03:50 AM Eva L. Cornelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖫 F Months 214-30-6289 Director March 11, 1912 U.S.A. Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shor Director 1 ☐ Yes 2 X No Maryland Anne Anumbel Annapolis 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21401-1054 U.S.A. 1801 River Watch Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ No Specify. \$ 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic event, I'm once. 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Harrison Parks ပ Anna Ennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Lawlor - Son-in-Law <u> 1801 River Watch Iane, Annapolis, Maryland 21401-1054</u> 20b. Place of Disposition (Name of cometery, crematory, or other place)
Evans Funeral Chapel & Cremation Services 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12/15/2008 Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Parkville 21. Signature of Funeral Service Licensee Telkey 1esterman 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Filure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed Due to (or as a consequence of): attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Day 5 Other (specify) 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide NUESE Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RACTITIFE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Justine Trees CRNP R043580 12-15-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAK CREST RENAMSANCE GARDENS

TUSTINE PREIS CRNP 8832 WALTHER BLUD. BALTO, MD 21234 32. Registrar's Signature

Baltimore, Maryland 21215-0036

68760

Box

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Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** December 3 2008 /Medical 4b. City, Town, or Location of Death Gounty of Death Facility Name (If not institution, give street and number) Examiner Heapid oward ten 0 If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1□M 2 70 214-49-5180 Director Jan 9, 1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No West Friendship Director MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 2 12350 Fox Meadow Ln. 21794 Pakistan Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced rahistan Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) did not work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fagir Dean Allah Rakhi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1036 N. Walnut St. Milford, DE 19963 Shauket Dean 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 13, 2008 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens Marriottsville, Maryland ignature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City. MD 21043 Approximate Interval Between Onset and Death Part I. Liver the all end shock, or heart failure. complications that collised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ww R Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o as a consequence of): Examine Due to (or as a consequence of): Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 NO 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 □Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 29a. Certifier 🛰 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, KHE KU N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** WILLIAM EDWARD DAUGHADAY, JR. December 16, 2008 /Medical 7:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number .Sex M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 81 219-22-7558 Oct. 28,1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Baltimore County Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle Apt. 322 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 yrs. 3 yrs. Teacher Teaching Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edward Daughaday, Sr. Alma Erdman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type. Print) 300 International Circle Apt. 322 Cockeysville, Md. Hazel M. Daughaday (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-19-2008 Parkwood Cemetery Baltimore, Md. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Lassahn Funeral Home F. 6. 7401 Belair Rd. Baltimore, Md.21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia disease or condition resulting in death) Due to (or as a consequence of): phoumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or s a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Division of Vital Records, peen law The or Attending Physician:

attending physician and for use as the burial-transigned by the s certificate has b rector, page 2 sh After this of funeral dire within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

**Funeral** 

Director

nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expression must be notified at

i and Mental Hygiene.

Health am 27 i

**Physician** 

/Medical

Examiner

Pages 1 permit. Pages Department of Important: If it any injury or o once.

Saltimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

3 5+ parle 31. Date filed (Month, Day, Year)

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State of M	arylan		artment of F rtificate of		_	giene Reg. No.	U8	40567
	Physicia	an	1. Decedent's Name (First, Mic						2. Date of De Month	ath	Ye ar	3. Time of Death
	/Medic	al	Anna Marie D  4a. Facility Name (If not institu				41. 07. Town	- l ti t D t	Decembe		8008	2:44 P <sup>M</sup>
نر	Examin	er	Glade Valley	tion, give street and number)			Walkersv	r Location of Deat	tn	4c. Count		
	Funeral Director		5. Social Security Number 215-03-3324	6. Sex 7. Ag	e (In yrs. I 93	last birthday) Yrs.	If Under 1 Year Months Days			1, 1915	9. Birthp Cour	olace (State or Foreign ontry) Maryland
	and wo		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City	y, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sho	ż	MD Fred	erick	Walk	ersvi	11e					1 ☐ Yes 2 ▼No
	or 28	Direc	10e. Street and Number		J		10f. Zip Code			10g. Citizen of	What Coun	try?
	sath w	Funeral Director	56 W. Frederi	ck Street  12. Was Decedent	Cuer in III	0 40	21793	lianania Osiaia 2 (	2	USA		and the state of
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Memtal Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experimental must be notified at	5	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ፟፟ Widowed 4 ☐ Divoro	arried Armed Forces?	No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🂢 No	an, Mexican, Puer	to Rican, etc.)	Specif	ce - Americ ck, White, e	
ה ה	72 hou natura	eted	15. Deced	ent's Education hest grade completed)		16a. Dece	dent's Usual Occup	ation during most of wa	rkina i	16b. Kind of B		
7	within ene. than "	Completed	Elementary/Secondary (0-12		5+)	'life.' . Homema	kind of work done of NOT use retired	d)	9	Own Ho	me	
2	filed Il Hygi other ent, Il	Be Co	17. Father's Name (First, Midd			TTOMO		18. Mother's Na	me (First, Middle,			
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2	and 2 should be filed withi ealth and Mental Hygiene. n 27 is marked other than ner traumatic event, the M		19a. Informant's Name/Relation Mary D. Kemp	nship <i>(Type. Print)</i> / daughte	r	I .	ng Address (Street					Code)
ָ ע	s 1 and 2 f Health tem 27 other tr		20a. Method of Disposition	, daughte			cobble Co esition (Name of matory or other place		Date	20c. Location		wn, State
	Page: nent o ant; If Iry or		1 🕅 Burial 2 🔲 (remation 4 🗍 Donation 5 🗍 Other	n 3 ☐ Removal from State			, Redeeme		8/08	Baltimo	re, M	1D
Dallino	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once.		21. Signature of Furey lerv	Serf Charles			2. Name and Addre		1 Home		York n, MD	Road 21204
F	Physician		23a. Part 1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	or complications that caused ist only one cause on each li	I the death	. Do not ent						Approximate Interval Between Onset and Death
)	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience o /.	01111	1	DIJED:			LVERS
)		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ience of):			The		-	
V	scuted nd transit	Examiner	Cause (Disease or injury that initiated events	С								
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000	ificate g phys	edical		d								
	attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			ite of delive	ery Day Year
. 'CD	uires that the de signed by the d be detached	þ	Part II. Other significant cond	itions contributing to death b	ut not resu	lting in the u	nderlying cause give	en in Part I.		obacco use con		ably 4 Unknown
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י שו	ding Physician: The lav n. After this certificate has funeral director, page 2	e Completed	25. Was case referred to media	nal .				00 Di	autop perfoi 1 □ Yes	rmed2 2 No	prior to cor death?	ppletion of cause of
5	hysici	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Oth		ath <i>(Check only o</i> Home 5 ☐ Resid		ner (Specify	()
	ing Pl		27. Man of Death 1 ✓ Natural 5 ☐ Pend		ry y, Year)	28b. Time of Injury	Work	y at </td <td>28d. Describe h</td> <td></td> <td></td> <td></td>	28d. Describe h			
DISINIO	To the Hospital or Attending Physician: within 24 hours after death. To the Luneral Director. After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be rmined 28e. Place of Inju- building, etc	ury - At hor c. <i>(Sp</i> ec <i>ify</i>	me, farm, str	M 1 □	Yes 2 □ No	28f. Location (S City or Tow	Street and Numb vn, State)	per or Rurai	l Route Number,
	Hospital 24 hours Funeral etely filled	edical Co	29a. Certifier 1 Certific (Check only one) 2 Medic	ying Physician: To the best al Examiner: On the basis o and manner sta	f examinat	wledge, death ion and/or in	n occurred at the tirvestigation, in my o	me, date and plac pinion, death occi	e, and due to the urred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
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_	12		30. Name and address of person	65CTF	nom	25 Jc	Print)	Dr. Fre	ederid	K.MD	217	02
	Stat Registra		31. Date filed (Month, Day, Yea  DEC 1 9	9	ar's Signati	ure	S. s			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Ronald John Emkey 12:58 P M 17,2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center For Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 9, 1942 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 220 36 7700 66 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Experiment is ust by muffled at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7922 Landsdale Rd. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman Soap Manufacturer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin F. Emkey Edna A. Rode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau 7922 Landsdale Rd. Baltimore, Maryland 21224 Mayfe Emkey (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Inc. 12/18/2008 |Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service tricensee W okn 23 P rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASTROCYTOMA WEEKS /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. ned by the a detached f 9 Unknown has been signed e 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 2 No 2 No 1 ☐ Yes sion of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐ Yes 2 No ۵ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21204 DANIEUE DOBERMAN, MD 6565 N CHARLES ST, SUITE 209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd 10b-c, 10e-f, per FH G88/1/5/09 TT

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Marie Rose Elliott 15, 8:47 P.M 2008 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🔀 F Months Days Hours Min. 89 214 46 2122 Director 03/23/1919 Maryland Usual Residence of Decedent Anne Arundel 10c. City, Town or Location Heights with the Maryland 10a. State 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Director 1 ☐ Yes 2 🗓 No Westminster Maryland Carroll 10f. Zip Code 21090 10e Street and Number Road 10g. Citizen of What Country? Funeral P.O. Box 1662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ş Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any injury or other traumatic event, the gonge. 11th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Eckert Elizabeth Balk ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Elliott / Son P.O. Box 1662 Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2008 Glen Burnie, Maryland Glen Haven Mem. Park 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Iraniouski 4001 Ritchie Highway Baltimore, Maryland 21225 231. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTICEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unisease or injuly that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitioner and on the cause(s) are proposed by the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of ca 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year)

State Registrar

Records, P.O. Box 68760

Division of Vital

TIMONIUM.MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17:04 GERALD EINBINDER 2008 ecomber /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A UNION MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 08/06/1946 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** MD 219-44-8651 62 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner is used by notified at once. 1 X Yes 2 No Director N/A MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 2500 W. BELVEDERE AVENUE, #605 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No WHITE Specify: ğ 3 ☐ Widowed 4 🛱 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EINBINDER RUTH MAX ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARRY ASH / COUSIN 10700 PARK HEIGHTS AVE., OWINGS MILLS, MD 20b. Place of Disposition (Name of ANSHE) EMUNAHOUR PP2 CHAIM CONGREGATION 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 12/18/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** 4 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VENOUS THROMBOSIS IN KNOWN SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DISBASE burial-transi END STAUG RENAL UNKNOWN nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Month Year signed by the atte 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, I or Attending Fafter death. within 24 hours after death To the Funeral Director: Hospital

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 16 2008 amuetha

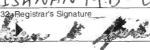
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMRUTHA BALAKRISHNAN M.D UNION MEMORIAL HOSPITAL, MD 31. Date filed (Month, Day, Year)

State Registrar

Medical

DEC 13 2008



State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CARROLL E. FREELAND DEC. 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 43100 GLENMORE AVE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
DEC. 20,1913 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 ▼ M 2 □ F 212-01-4811 94 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1∏Yes 2∏No Director MD N/A BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 4300 GLENMORE AVE 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY POLICE ENFORCEMENT STATE OF MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS C. FREELAND ESTELLE BAKER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA FREELAND-WIFE 4300 GLENMORE AVE BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) PARKWOOD CEMETERY 12/18/08 BALTIMORE, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Signatur of Furieral Vivice Lie BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** metastetic /Medical Due to (or as a consequence of) **Examiner** CAL Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit physician and The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the a should be detached t ☐Yes 2☐No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has be rector, page 2 s autopsy performed 2 No 1∐ Yes To the Hospital or Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satt 515 150 Registrar's Signature 31. Date filed (Month, Day, State Registrar

			For State Registrar	State of Marylan		artment of H		lental Hygie	ZHIR	40573
F			Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medio		Margaret F	owlkes					Day Year	3 9:15 AM
	Examin		4a. Facility Name (If not institution, given Multi Medical	re street and number)		4b. City, Town, or Towson	Location of Death		4c. County of Dec Baltimo	
	Funeral Director		5. Social Security Number 6. S 216-16-4136	Gex 7. Age (In yrs. 1 ☐ M 2X F 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 16,	9. Bi	rthplace (State or Foreign Country) ITY1and
	pu ,		Usual Residence of Decedent	100 0	y, Town or Lo					10d Inside Cit. Limite
	show	ř	10a. State 10b. County N		y, rown or co altimo:					10d. Inside City Limits 1
	the M	Director	10e. Street and Number	, , ,		10f. Zip Code		10a.	Citizen of What C	Country?
	death with the Maryland ms 23a or 28a-f show rmst benotified at	i Di	812 N. Mount S	treet		212	17		US	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V		ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
2-003p	urs after al', or Ite	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:		Tes, specify Cuba	Specify:	riicari, etc./		lack
ה ה	72 ho	sted	15. Decedent's E		16a. Deced	lent's Usual Occupa	ation during most of worki	na 16t	. Kind of Busines	s/Industry
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ylana,	d be filed ental Hyg red othe c svent,	Be	17. Father's Name (First, Middle, Last Uilliam Colema	•			18. Mother's Name	(First, Middle, Maio Lashingt		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic svent, the Medical Examiner must be notified at ance.	2	19a. Informant's Name/Relationship (	Type, Print)			and Number or Rura Street Al			
a)	ges 1 and t of Heali		20a. Method of Disposition 1   Burial 2 □ Cremation 3 E	20b. F	Place of Disposemetery, cren	sition (Name of natory or other place	! 0	Date 200	Location - City o	r Town, State
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ğ	Depa Depa Impo any ir		MI	3		<u> 1050 Y</u>	ss of Facility owson Fun ork Rd. T	owson, Mc	1. 21204	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ente	er the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
12	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. DIABE		MELLI	745			years
	/Medical Examiner		1	Due to (or as a conseq	uence of):					200
	100	er	Sequentially list conditions, if any, leading to immediate	b. SEPS 15 Due to (or as a conseq	uence of):					11975
	xecuted and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. FAILUR Due to (or as a consequence)	E 7	0 74	RIVE			monetos
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0	tificati ig phy as the	(I)								
.C. BOX	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree Unknown	ıldeath 3⊡	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
7	s that ned b e deta	by Pr	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobaco	co use contribute	to the cause of death?
coras,	aquire en sig ould b				-			1 🗆 Yes	2 □ No 3 □ F	robably 4 Unknown
Ľ	e las	Completed						24a. Was an autopsy performed	l? death?	utopsy findings available completion of cause of
Vital	icien: The certificate rector, pag	ВеС	25. Was case referred to medical examiner?				26. Place of Death			
o   	Physicien: r this certific ral director,	၉	1 ☐ Yes 2 ☐ No		ER/Outpatien		Nursing Hor	ne 5 ☐ Residence	<u>-</u> <u>-</u>	ecify)
	ding Physicien: h. After this certific funeral director,	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injun Work	/ at k? Yes 2 □ No	28d. Describe how is	njury occurred	
UNISION	To the Hospitet or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	De One Plane of Injury At h	ome, farm, stre			28f. Location (Street City or Town, St	t and Number or F tate)	Bural Route Number,
ב	spitet ours a veral E		29a. Certifier ,1 Certifying Pl	hysician: To the best of my kno	wledge, death	occurred at the tin	ne, date and place	and due to the cause	e(s) and manner a	s stated.
	the Hos hin 24 h the Fur npletely	Medical	one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	ition and/or inv	restigation, in my o	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
	To cor		29b. Signature and title of certifier	0		290. LICENS		290.	- A I C	Day, real)
	1		5000 Jet M 30. Name and address of person who	completed cause of death (Item	n 23a) (Type	Print)	03313	U D	(01)	2008
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	,				
	Registr	ar	DEC 1 9 2008	Bullion As 1	and the second					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year a<sup>M</sup> **Physician** 2008 December 9:30 Fritz 16 Anna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 12 Glenbrook Drive Phoenix 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 7, 1926 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Days Min 1 □ M 2 □**X**F 82 Director 216-20-2750 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Baltimore Phoenix 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21131 12 Glenbrook Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed whand Mental Hygier is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nyanelli Catherine Luigi DiMassimo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. Phoenix, 21131 <u>Mar</u>yland 12 Glenbrook Drive William F. Fritz Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland 4 □ Donation 5 □ Other (Specify) Hillton Service Corp. 12-22-2008 Towson 21. Signature of Fibraral Service Licensee 22. Name and Address of Eacility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 day Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and law requires that the death certificate be execu-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 🛣 No ned by the a detached if 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autonsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 🙀 Natural 5 Pending investigation the Funeral Director. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D22652

State Registrar

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10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. SUBRAMANIAN SRINIVAS 5601 LOCHRAVEN BLVD BALTIMORE MD 21239. 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 4:00 M 2001 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner OtoMAC Montgomer Fox Hollow D If Unde f Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 246-58-7325 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 96 Months Days Hours Min. 0170871912 Yrs NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.s. permany injury or other traumatic event, Ille Marked of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Montgomery Potomac 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9401 Fox Hollow Drive 20854 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 □Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced 16a Decedent's Lisual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Owens Mary Hall 19a. Informant's Name/Relationship (Type. Print)

John Gibbs / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Travelodge Drive, El Cajon, CA 92020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Forest Hill Cemetery 12/20/2008 Morganton, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio- Pu/MONANY /Medical Examiner evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Orteo Jevere burial-tran Due to (or as a consequence o Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1☐Yes 2☐No 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J Vaugh I.M. 31. Date filed (Month, Day, Year) MD 3500 32 Registrar's Signature State Registrar

## State of Maryland / Department of Health and Mental Hygiene

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Physician
/Medical
Examiner

**Funeral Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinar must be redified at adness.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760元

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	Registrar				incate of				Reg. No					
	Month Day Year									3. Time of De	eath			
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r	4a. Facility Name (If not institution, give street and number)				4b. City, Town, o	r Location of	f Death		4c. County of Death				im	
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	5. Social Security Number 6. Sex	7. Age	(In yrs. last birt		If Under 1 Year	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	h V Voer)		9. Birth	place (State or F	orei <i>gn</i>	
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<u>ie</u>	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?							
Funeral Directo	7521 Lawrence Roa	ad				2	United States							
Jer	11. Marital Status	13. W	as Decedent of F Yes, specify Cuba	lispanic Orig	gin? (Spec	cify Yes or No-	o- 14. Race - American Indian,							
Ē	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No						, Puerto R	lican, etc.)	Black, White, etc.					
	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	□Yes 2X No	Specify:				Specify		hite		
Completed by	15. Decedent's Educ	cation	16a.	Decede	ent's Usual Occup	oation			16b. K	ind of Bu	ısiness/In			
<u>e</u>	(Specify only highest grade	completed)	`	(Give k.	ind of work done O NOT use retired	during most ( d)	of working	g						
E	Elementary/Secondary (0-12) 7 Years	College (1-4or 5-	+)	Hon	nemaker				C	wn F	<b>lome</b>			
	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (	(First, Middle,	Maiden	Surnam	ie)			
Be	Enrico Maulone					Jul	Lia J	<b>Julian</b>						
9	19a. Informant's Name/Relationship (Ty	no Print)	10h	Moiling	Address (Street				or City	or Town	Ctoto Zi	n Cadal		
	Mr. Frank Geiger,				Denrob							21234		
	20a. Method of Disposition	020 (201	1				Da					own, State		
	12℃ Burial 2 ☐ Cremation 3 ☐ R	emoval from State			ition (Name of atory or other place								_	
	4 □ Donation 5 □ Other (Specify)		Sacred	Ht.	. of Jes	us Cen	n. 12	2/19/20	80	Dung	dalk,	. Maryla	ınd	
	21. Signature of Funeral Service License	4	1	22 Di	Name and Addre	ss of Facility Funer	al H	lome of	Dur	ndall	s, Ir	nc.		
	23a Part 1 Enter the disease or compli	cations that caused	the death. Do n	ot ente	22 Wise	AVE.	DUIX	respiratory ar	vicit y	Tano	212	Approximate	-	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.										Interval Betwe Onset and Dea	en ath		
	disease or condition  a. END STAGE LEN AL DIJ EASE  ALEN ALLEN ALL										SYR			
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DHMH 17 Rev 1/2001

State

Registrar

DEC 1 9 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MOUDOUTE GILBERT くingU巨 2008 17:07 PM 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore of Maryland Baltimore Cita university 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Hours Maryland 2-5 2008 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14035 Castle Blvd #304 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 ☐ Married 1 □Yes 2 X No Specify. black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Laure Ngardo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Med Ctr 22 S. Greene Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ★ Other (Specify) 17 State esticensee de, Konaid State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate truse (Final disease or condition resulting in death) a. The property of the mode of dying, such as cardiac or respiratory arrest, shook or heart failure. List only one cause on each line. Cerebral how resulting in death) a. Intra parenchymal cerebral hemorrhag Due to (or as a consequence of): 2 da Thromocy to penia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Twin Assisted Gesto 2 **X**No 25. Was case referred to medical examiner? technolog 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 2 ER/Outpatient 3 DOA NД Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred

28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) D33573

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 9

South Greene Street, Baltimore 21201 MD 22 Ellen

State Registrar

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

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Examine

**Funeral** 

**Director** 

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Event has been clined at

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumation.

**Physician** 

/Medical Examiner

attending physician and for use as the burial-trar

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signed by 1 d be detach

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has page 2 s

this certificate

After

within 24 hours after death
To the Funeral Director:
completely filled in by the

funeral

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital

the Hospital or Attending Physician:

death.

72 hours after

Baltimore, Maryland 21215-0036

## 1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

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Physicia /Medica

**Funeral** 

Examine

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Michael Evaning in units by notific at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, La	ast)						2. Date of Dea		ay Yea	ır	3. Time of Death		
n	Kenneth L. Grimm DELEGAN 51.1							211, 20	1, 2008 5:30A					
r	4a. Facility Name (If not institution, gi	4	4b. City, Town, or Location of Death				41	4c. County of Death						
	Washington Cou	nty Hospit	:a1		Hagerst					Washing				
		Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last b	, triday	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	v. Year	r)	Count			
	215-36-6585	A W Z L I	72	Yrs.				May 2,	193	36 V	irg	inia	_	
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Locat	tion						10	ld. Inside City Limits	-	
ō	MD Washing	rton		agers								1 □ Yes 2√€ No		
rec C	10e. Street and Number		110	18010	10f. Zip Code				10g. C	itizen of What	Count	ry?	-	
	16421 Leon Grimm	n Drive			21740					USA				
Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S			13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				ecify Yes or No	lo- 14. Race - American Indian, Black, White, etc.				-	
Ē	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 📉					Rican, etc.)							
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etec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give				dent's Usual Occupation kind of work done during most of working					16b. Kind of Business/Industry				
ᇤ	Elementary/Secondary (0-12)	College (1-4or	5+)		ive kind of work done during most of working a. DO NOT use retired)  truck driver				transportation					
ပိ	17. Father's Name (First, Middle, Las	·/			cruck di		er's Name	e (First Middle	transportation  Middle, Maiden Surname)					
Be	Leon Martin Gri	_						argaret						
9					Address (Street :						7in	Code)	_	
	Elaine Grimm/s				Leon Gr							740		
	20a. Method of Disposition		20b. Place	of Disposit	ion (Name of tory or other plac	-)	[	Date	20c.	Location - City	or Tov	wn, State	_	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🖾 Donation 5 ☐ Other (Spec		e	ery, crema	tory or other plac	<i>e)</i>								
	21. Signature of Euneral Service Lice Ronald S			22.1	Name and Addres	s of Facilit	hard	1 655 W	Ra	ltimor	2 5	treet	_	
	Ronard S.	wave, Di.	~		ltimore,	_	2120		Do	LLCIMOL		2222		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between				
	immediate Cause (Final disease of sondition		· kosh	14.	1 + 11	a . l-	1.					Onset and Death		
	resulting in death)		s e consequence		2( ) 20	r.c.rc	(6)				+	( ),((),()	_	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inilitated events c.													
Хаш	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):								+		_			
E E	Due to (of as a consequence of).													
cian/Medical Examiner		d											_	
Š	IF FEMALE: 23b. Was decedent pregnant	23C If yes outcome of pregnancy								23d. Date of	delivery			
	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant	2 ☐ Fetal deat at time of death		Ectopic pregnanc Other <i>(specify)</i>					Month		Day Year		
hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown										_			
Š	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing						use contribute	ute to the cause of death?						
ed								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow						
plet								24a. Was	24a. Was an autopsy prior to com			osy findings available apletion of cause of		
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in F								perfo	rmed?	death	death? 1 Yes 2 No			
25. Was case referred to medical     26. Place of Death (Check of							h (Check only o	ne)				_		
examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)								pecify	)	_				
 0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, E	ijury 28b. Da <i>y</i> , Ye <i>ar)</i>	. Time of Injury	28c. Injur Worl	ς?		28d. Describe	now inj	ury occurred				
cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not		M 1 🗆						_					
Ē	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  5 Home, farm, street, factory, office building, etc. (Specify)								Hurai	Houte Number,				
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es state									ated.	_				
Topatient   Impatient   Impa														
Me	29b. Signature and title of certifier				29c. Licens	e number			29d. D	ate signed (Mo	onth, E	Day, Year)		
	Michael	no	10 041667 12.11.08						, E					
	30. Name and address of person wh		death (Item 23a	ı) (Type, Pr	int)			4					_	
	Michael McCo			redic	cel Com	pui	1/2	sersho	vn	MP			_	
е	31. Date filed (Month, Day, Year)		strar's Signature	B, . 1	r. a									
ır	DEC 1 9 20	008	J. K.	134	K.								_	
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DHMH 17 Rev 1/2001

Sta Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0736AM DECEMBER EDGAR 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days 172-42-1072 57 June 18, 1951 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Baltimore 1 ▼ Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1029 E. Baltimore Street 21224 USA Funeral unk 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces'

1 X Yes 2 □

If Yes, Give

Year or Dates: 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) mechanic automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Francis Gettz Sr Marjorie Hunt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Jeanne Delp/sister 3329 Forge Hill Road Street, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□ Donation 5 Other (Specify) in state 21. Signal re of Euneral Struce Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ##irector Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 DAYS disease or condition /Medical resulting in death) Examiner 4 0.445 Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualty (or as a consectue The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy fo in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗆 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to 9 1 Tes 2 🗖 o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas page performe Yes 2 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one, Be examiner? Other: 4 \( \) Nursing Home \( 5 \) \( \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 9 this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: hours after death. uneral Director. After the ely filled in by the funera or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, An 24 hours The Funeral Dire. 4 🗌 Homicide City or Town, State) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Funer completely fi Medical (check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE F. SABATH 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 172008 Donald Guido December 1:55 pm M Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3602 Wheelhouse Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/28/1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours 219-30-6375 1 □ M 2 □ F 73Yrs Director Florida Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, If yo Medical Examirar must be refilled at Maryland Baltimore Middle River 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3602 Wheelhouse Road 21220 USA filed within 72 hours after death 1 Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No <u>≨</u> Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Painting Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be lealth and Mental Mary Electa Nelson Robert Tony Guido 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3602 Wheelhouse Road, Baltimore, Maryland 21220 Robert Guido, Jr. (Son) Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gard. 12/19/2008 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex.Md. 21221 20a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death l mediate Cause (Final se or condition resulting in death) **Physician** UN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trans and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' certificate 2 No 1 ☐Yes 2 ☐Mo Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 🗓 Mo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 Natural o the Hospital or Attending Plantin 24 hours after death.

o the Funeral Director; After the completely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number

State

Registrar
DHMH 17 Rev 1/2001

84

N. EVTAWST # 305 BACTIMONE MAZIZON

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MNAN

32. Registrar's Signature

ANANDA

DEC 19

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	iryiand / Dep <i>Ce</i>	ertificate of		,	giene Reg. No. 2 () ()	8 40681	
	Physici	an	1. Decedent's Name (First, Middle Terry Paul Gajo			<del>.</del>		2. Date of Dea Month	Day, Yea	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Dea	DECEMBE	4c. County of De		
ممر.			Union Memorial				imore		Baltimo	,	
	Funeral Director		218-40-0926	6. Sex 7. Age 1 1 M 2 □ F 66	(In yrs. last birthday	Months Days	If Under 24 Hrs Hours Min		<sup>h</sup> Year) 9. E 1942 Ma	Birthplace (State or Foreign Country) Bryland	
	yland Now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	e Mar	ctor	Maryland Baltim	iore	Ва	ltimore C	County			1 □ Yes 2 □ <b>X</b> No	
	with the	Director	10e. Street and Number 6715 Harewood F	ark Drive		10f. Zip Code	.220		10g. Citizen of What	Country?	
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H		Specify Yes or No-	USA 14. Race - Ar	merican Indian,	
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Event har institut by neithed at	þ	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  **XXYes 2   No If Yes, Give Year or Dates:	0	1 □Yes 2 X No	Specify:	rto Hican, etc.)	Black, Wh	<sub>lite, etc.</sub> White	
15-C	"natur	letec	15. Decedent' (Specify only highes	s Education ! grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kind of Busines	ss/Industry	
717	d within 72 giene. r than "na the wedic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+N/A	-1	-Presiden			Trojan Ala	arm Solutions	
yland	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, L						Maiden Surname)		
ž	2 should be and Menta is marked aumatic en	P L	Leo Paul Gajdos  19a. Informant's Name/Relationsh		19h Mail	ing Address (Street		Caroline	In⊥e er, City or Town, State	Zin Cada)	
, Mar	and 2: ealth a n 27 is er trau		Leona M. Gajdos						timore, Mo		
baitimore,	permit. Pages 1 and 2 should be Department of Heath and Menti Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State		osition (Name of matory or other place		Date	20c. Location - City		
altin	mit. Papartme partme portant / injury	1	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Fuheral Service L		. 2	ematory I	ss of Facility		Baltimore	e, Md.	
מ	permi Depa Impo any ir once.		Forsel	2 C. Clas	salu	Lassahn Fi 7401 Bela:	ir Rd. B	altimore.	. Md. 2123	6	
1			23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final				ig, such as cardia	c or respiratory ari	rest,	Approximate Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	- W.	DIOGENIC consequence of):	SHOCK				3 HOURS	
	Examiner		Sague Mally list our ditions,	ACLITE MYNCARDIAL MIENROTTANI							
5	uted d ansit	mine	causé (Disease or Injury hat initiated events CORONARY ARTERY DISEASE							UNKNOWN	
00,	tificate be executed ig physician and as the burial-transit	edical Examiner	resulting in death) Last	·	consequence of):	70.11		<u></u>		C10 KN 00014	
00/00,	tificate ig phys as the l	ledica		d							
S C	ath cer attendir or use	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	☐ Ectopic pregnanc	y		23d. Date of o	lelivery Day Year	
	t the de by the a ached f	Physic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at t	time of death 5	Other (specify)			Wionth	Day rear	
colds,	res t	þ	Part II. Other significant condition	s contributing to death but	not resulting in the u	inderlying cause give	en in Part I.			to the cause of death?	
2	law rec as bee 2 shou	Completed						24a. Was a		autopsy findings available	
ב ב	i: The licate h							autops perfori 1 □ Yes	med? death?		
<u> </u>	ysicial is certi directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 Dippatient	t 2 ☐ ER/Outpatie	nt 3 DOA Othe		ath (Check only on	ne) ence 6 ⊡Other (Sp		
5	ding Physician: The Inc. After this certificate ha funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	28b. Time o		/ at	7	ow injury occurred	есіту)	
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5	ortal or urs afte sral Dir illed in		4 Diomicide					City or Town	n, State)		
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i	vithii To th	ğ	29b. Signature and title of certifier	A 0		29c. License		. /	29d. Date signed (Mor		
			30. Name and address of person w	/	oth (Itom 20c) (T.::		24389	40	DECEMBER	16th, 2008	
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	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature						

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ORIGINAL.

**Funeral** Director

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene On the O

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyolene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at
Division of Vital Records, P.O. Box 68760, &	all or Attending Physician: The law requires that the death certificate be executed as a stier death.	I Director: After this certificate has been signed by the attending physician and din by the funeral director, page 2 should be detached for use as the burial-transit

•	1 - State Registrar		•	Certific	ate of i	Death		F	Reg. No.		0	-} U !	200
	1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea Month	ith Day	y Ye	25	3. Time of	Death
ו		Margie Ma	arie God	frey			De	ecembe				9:19	A . M
r	4a. Facility Name (If not institution, give		-		ity, Town, o	Location of	Death		4c.	County of D	eath		
	8338 Roferd Ave	nue				timore				Balti			
	5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birt	hday) if Un Mont	der 1 Year hs Days	If Under 24 Hours	Min. 8.	Date of Birtl (Month, Day	y, Year)		Countr		or Foreign
-	228 56 0164 11		66	113.				02/28	/194	2	Virg	ginia	
ŀ	10a. State 10b. County		10c. City, Town	or Location							100	d. Inside Ci	ty Limits
į	Maryland Baltin	more	Ba1	timore								1 □Yes	2 🗓 No
9	10e. Street and Number				Zip Code				10g. Cit	izen of What	Countr	y?	
rai Directo	8338 Roferd Ave	enue			2	1237				U.S.A			
9	11. Marital Status	12. Was Decedent I Armed Forces?	er in U.S.	13. Was De	cedent of H	ispanic Origi an, Mexican,	n? (Specif	y Yes or No- an, etc.)		14. Race - A Black, W			
y ru	1 Never Married 2 Married	1 ∐Yes 2 🛣 N If Yes, Give	10		2 X No	Specify:				Specify:			
pieted by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160	Decedent's U	leual Occur	ation			16h Ki	ind of Busine	Whi		
Siett	15. Decedent's Ed (Specify only highest grad	de completed)		(Give kind of life. DO NO	work done of T use retired	during most c t)	of working	i	TOD. IX	ind of Dasine	233/11100	isti y	
E	Elementary/Secondary (0-12) 9th	College (1-4or 5	+)	Homema						Own 1	Home	9	
ē C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (F	irst, Middle,	Maiden	Surname)			
0		Wade Jack	son Dove	•			Ruby	Power					
	19a. Informant's Name/Relationship (7			Mailing Addr					-				
	Kathy Brady / Da	ughter		646 Ha						ore, M			21225
	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Disposition ( y, crematory	Name of or other plac	re)	Date		20c. Lo	ocation - City	or Tow	n, State	
	4 ☐ Donation 5 ☐ Other (Specify		Druid	Ŗidge	Cemet	ery 1	2/19	/2008	Ba1	ltimor	e, N	Mary1a	and
	21. Signature of Funeral Service Licen			22. Name	and Addre	ss of Facility	Gond	ce Fun	era1	l Serv	ice	P.A.	
	7.5	manne		4001						ore, Ma			
	23a. Part 1. Enter the disease, or my shock, or heart failure. List only	one cause on each lir	ne.					espiratory ar	rest,			Approximat Interval Bet Onset and I	ween
	Immediate Cause (Final disease or condition resulting in death)	a. CURO	napry	ry aftery disease							y	ears	
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L G	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	estive a consequence of	of):	il ja	une			geus				
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EX S	resulting in death) Last	Due to (or as	a consequence of								0		
ca Ca	(	d. De	aletes	mee	liles						8	KOUS	
wedical	IE CEANLE												
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2  Fetal death	3 ☐ Ectop	ic pregnanc	У				23d. Date of			Year
sician	in the past 12 months? 1 ☐ Yes 2 ☐ Mo	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 Other						Month		Day	rear
P.D	9 ☐ Unknown	ontributing to death b	it not resulting in	the underlyin	na cause aiv	en in Part I		23e. Did to	bacco i	use contribut	te to the	cause of o	leath?
2	Taren. Other significant conditions of	onthibuting to doubt b	at not resulting in	the underlyn	ig oddoo giv	orran arti.		1750			] Proba		Jnknown
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De	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 o	Hospital:			DOA Oth	or.		Check only o		• <b></b>			
0	27. Manner of Death	1 ☐ Inpatie		tpatient 3 ☐ ime of	28c. Injur	y at		I. Describe h		6 ☐ Other (8 ry occurred	Specity)	)	
0	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y, Year)   li	njury M	Wor 1 □	k? Yes 2 ∐ No	0						
E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, et	ury - At home, fai	m, street, fac	tory, office		28f	Location (S	Street an	nd Number o	r Rural	Route Nun	ber,
Ser	4 - Horricide	building, et	s. (Specify)					City of Tow	ni, State	=)			
Medical Certification:	29a. Certifier Check only one) 12 Certifying Ph	ysician: To the best niner: On the basis o and manner st	f examination an	death occur dor investiga	red at the ti	me, date and ppinion, death	place, and occurred	d due to the at the time,	cause(s date and	and manne d place, and	er as sta	ated. the cause(s	;)
Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Da	te signed (M	lonth, D	lay, Year)	
	Marmen	le Ino	een N	110	00	008	09	3	/	278	-0	8	
	30. Name and address of person who	completed cause of d	eath (Item 23a)	Type, Print)	0/10	ш.О.	211	210					
9	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	- 136	CUN		010	+10					
r	DEC 1 9 2	008	es the	Speed	2						-		

DHMH 17 Rev 1/2001

Stat Registra

			1 - For State Registrar			Certificate of D	eath	Re	eg. No.2008	40000
	Physicia		1. Decedent's Name (First, Middle, Last)  Robert L. Glue					2. Date of Death Month December	Day Year	3. Time of Death  12:00P M
	/Medic Examin		4a. Facility Name (If not institution, give s		*	4b. City, Town, or L	ocation of Death	Decembe	4c. County of Deatl	
			4100 North Charle	s Street Ap	ot. 201	Baltimo	ore		N/A	
ı	Funeral Director		031-14-3001	7. Age (In	yrs. last birthe 84 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 31	, 1924 Ne	hplace (State or Foreign untry) W Jersey
	land ow		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town o	r Location				10d. Inside City Limits
	Mary	ţō	Maryland N/A		В	altimore				1∑Yes 2□No
	h the	irec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cou	untry?
	23a c	ral	4100 North Charles	Street Ap	t. 201	212	218		USA	
12-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the hielder Evenities must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	1944 1946	13. Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 X No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
ဂ ဂ	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation e.completed)	16a. D	ecedent's Usual Occupat Give kind of work done du fe. DO NOT use retired)	tion Irina mast of worki	na l	16b. Kind of Business/I	ndustry
7	ithin ne.	m p	Elementary/Secondary (0-12)	College (1-4or 5+)		te. DO NOT use retired) essor of Ph				
N	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		11101		18. Mother's Name		<u>Jniversity of</u>	Maryland
and	be d all	To Be	Louis Gluckstern					Dworkir	,	
ary	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic	۴	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. N	failing Address (Street ar				lip Code)
Ě	らもに き		Elizabeth Nuss, Wi	fe	410	0 North Charle	s Street A	pt. 201 E	Baltimore, MD	21218
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	2 amoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other place,	)	Date 2	20c. Location - City or 1	Town, State
Daltimo	t. Pag tment tant:	١.	4 □ Donation 5 □ Other (Specify)	lemoval nom state	Metro (	Crematory In		8/08 E	Baltimore,	Maryland
ם	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License Thomas Gregor	reg		22 Name and Address Cremation 299 Freder	Society ick Road	Of Maryl Baltimo	land, Inc. ore, Maryla	nd 21228
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do no					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	DIFFUSE		LL LYMPHOC	THE LYP	1PHOM/	9	Onset and Death
	Examiner			Due 40 /00 00 000						
			1	Due to (or as a cor	nsequence of)	11.10.70.70.70.70.70.70.70.70.70.70.70.70.70				14 MONTHS
	20 11	ner	Sequentially list conditions,	Due to (or as a col						14 MONTHS
1	ecuted ind transit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a soi	iiSequeliče of)					14 months
, ,oc	be executed clan and purial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		iiSequeliče of)					14 months
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P	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a cord).  Due to (or as a cord).  3c. 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DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

GERTSEN

TIMONIUM, MD 21093

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year) DEC 1 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. cedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Decembe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Location of Death Examiner 8. Date of Birth (Month, Day, Year) Jan 9, 1935 if Under rthplace (State or Foreign **Funeral** Country Months Days Hours 1 □ M 2 □ F 73 Director 212-32-2254 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at MD Howard Dayton Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5045 Greenbridge Road 21036 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Given Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Landscaping Landscaper permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 is marked other a any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Edom Hammond, Sr. Edna Louise Miles ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing-Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Mrs. Eliza Louise Hammond 5045 Greenbridge Road Dayton, MD 21036 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bushy Park Cemetery 12/23/08 Cooksville, MD 21. Signature of Funeral Service Licensee HAIGHI FUNERAL HOME & CHAPEL, P.A. 1100164 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on e. c. line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 in the past 12 months? Month 5 ☐ Other (specify) 2 □ No □Yes P.O. the á ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Pobably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 1 ☐Yes 2 No Division of Vital 2 Was case referred to m-dical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending Injury death. 1 □Yes 2 □No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and market as scales (s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only

Hospital or Attending Physician: 24 hours after death Funeral Director: completely the 2

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

address of person who completed cause d

2008 9

Registrar

DHMH 17 Rev 1/2001

and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

			For St  St Registrar	ate of Maryland		artment of tificate of			giene Reg. No. 2 (	008	4,0686
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		JOAN			HOLT		Decemb	er 17	2008	16:37 M
	Examin	-	4a. Facility Name (If not institution, give street			4b. City, Town, o		Death	4c. Count		
			The Johns Hopkins Hospi			Baltimore		4 Hrs. 8. Date of Bir	N/		Jaco (State on Foreign
	Funeral		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. Ia	est birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da	ıy, Year)	Count	**
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1	or 28	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen of	What Coun	try?
	23a		5308 NORTH OAKS DR			274				USA	
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	perfin. rages I am Department of Heat Important: If item 2 any injury or other once.		1 ☐ Burial 2 【 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	di ironi otato				12/10/200	CATONIC	NTI I E	· MD
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	ac isit	Examine	at any leading to in rectable cause. Enter Underlying Cause (Disease or injury	Due to or as a conse ju	ience on						
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	mcare g phys as the	O I					·				-
XOX ROX	death certificate at for use as t	an/h	23b. was decedent pregnant	yes, outcome of pregnat		Ectopic pregnar	ncv			ate of delive	
	oean e atte	Physician/M	1 Ves 2 No	☐ Pregnant at time of de☐ Unknown		Other (specify)			141	lonth	Day Year
ב כ	ar me by th etach	Phy	9 Unknown  Part II. Other significant conditions contribu	ting to death but not resu	ulting in the u	inderlying cause.	siven in Part I	23e. Did	tobacco use cor	ntribute to t	he cause of death?
Ś.	r requires that the deam certifications been signed by the attending phe should be detached for use as t	l by	Recent Redo Acrt		opace	- 1	CY	1 🗆		3 🗌 Prot	
S .	w requir	etec	A	amering in				24a. Was	an 24b	. Were auto	psy findings available
Hecords,		Completed by	THE PLANT	1				auto perfe	psy ormed?	prior to co death?	impletion of cause of
= '	stolan: The law certificate has lirector, page 2		25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only of	2 No	1 🗌 Yes	2 🗆 140
5		To Be	examiner? 1  Yes 2 No Hospi	ital: Inpatient 2 🗆	ER/Outpatien	t 3 DOA O	thor	sing Home 5 - Res		ther (Specif	y)
ָם פַ	ding Pny th. After this funeral o			Ba. Date of Injury (Month, Day Year)	28b. Time o Injury		ury at	28d. Describe	how injury occu	urred	
Ď.	death. ctor. After y the fune	atio	Natural 5 Pending investigation	(, 22,,	,,		_Yes 2 □ N				
Division	r Atterder de recto	ertification:	3 Suicide 6 Could not be determined 28	Be. Place of injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location City or To		nber or Run	al Route Number,
<u> </u>	nrs af	O	29a. Certifier 1. Certifying Physician	a. To the hest of my know	vledae death	a occurred at the	time date and	t place, and due to the	cause(s) and n	nanner as s	stated
	Io the Hospital or Απεπαί within 24 hours after death.  To the Funeral Director. A completely filled in by the f	edical	(check only 2 Medical Examiner:	On the basis of examinat and manner stated.	ion and/or in	vestigation, in my	opinion, deat	th occurred at the time	, date and place	e, and due	to the cause(s)
	o the vithin ; o the отріє	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
4	- s <del>-</del> 0		Town The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of			RE	= 5 - 0	00	Decem	oes	17 2008
	3		30. Name and address of person who comple	eted cause of death (Item	n 23a) (Type,						
	D D		KAUSHIK MAN!					600 North We	olfe St, B	altimo	re, MD, 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Coast 5					

DHMH 17 Rev 1/2001

			1 - For State of Mary		rtment of He		ental Hygier	2000	3 40587
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	nder	tma	~K	2. Date of Death	T, EŠE	3. Time of Death  450 A M
	Examin		4a. Facility Name (If not institution, give street and number)	Los/Ra	4b. City, Town, or L	K5011	1	1c. County of Dea	th
١	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F  7. Age (In	n yrs. last birthday) 88	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea May 16, 1	1	rthplace (State or Foreign ountry)  MD
1	how			c. City, Town or Loc	ation				10d. Inside City Limits
2	28a-f s	ecto	MD Howard  10e. Street and Number		104 75- 0-4-	Fulton	1.40	Citizen of What Co	1 □Yes 2 No
4	3a or	ğ	7390 Pindell School Rd.		10f. Zip Code	20759	109. (		S.A.
5-003b	hall yighen.  Tall Hygiene.   d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13. W	Vas Decedent of His i Yes, specify Cuban ☐ Yes 2 \ No			14. Race - Ame Black, White Specify:	erican Indian, le, etc. <b>/hite</b>	
2	than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Gecondary (0-12) College (1-4or 5+)	16a. Deced (Give k life. D	lent's Usual Occupat kind of work done du DO NOT use retired)	iion Iring most of worki river	ng 16b.	Kind of Business  Retail Sa	/industry
ם מ	other vent, I	Be C	17. Father's Name (First, Middle, Last)				(First, Middle, Maide		ico Donvery
ylan	marked other	10 E	William H. Hundertn	1				a Stamfel	
£ .	ar is		19a. Informant's Name/Relationship (Type. Print)		-		l Route Number, City	or Town, State,	Zip Code)
_ , ,	other tr		Peter K. Hundertmark Son  20a. Method of Disposition 2		D PINGEII SCNO eition (Name of eatory or other place)		on, MD 20759 ate 20c.	Location - City or	Town, State
	nent of ant: If it ary or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Openio)		iatory or other place)	į.	18, 2008	Glen E	Burnie, MD
Baltimor	Department of Important: If i any injury or once.		21. Sum tire of Funeral Service Ucepe e		. Name and Address		A. te Ellicott City,	MD 21043	
	hysician /Medical xaminer	ər	23a. Part 1. Equer the disease of complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to many leading to ma	onsequence of);	Fig.	, such as cardiac o	or respiratory arrest,		Approximate Interval Between Open and Death
b8/bU,		edical Examiner	Sequentially list conditions, if any, leading to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (of as a condition) to the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the	nsequence of):					
DIVISION OF VITAL RECORDS, P.O. BOX 63 To the Hosnital or Attending Physician: The law requires that the death cartific	y the attending phase as the	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown  23c. If yes, outcome of properties of the past 12 months?  1 ☐ Live birth 2 ☐ The pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, F	s been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the unit	derlying cause given	ı in Part I.		\	o the cause of death? robably 4  Unknown
al Mecords,	After this certificate has be funeral director, page 2 sho	Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
VIII	certifi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient	O C FD/Outration	Othor	26. Place of Death	2		
101	ter this		27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of Injury	28c. Injury a	4 Li Nuraniy no	ne 5 Residence 28d. Describe how in		ecify)
DIVISION	within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification:	1 → Natural 5  Pending (Month, Day, Ye. 2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre	M 1 □Ye	es 2□No	28f. Location (Street City or Town, Sta	and Number or R ite)	ural Route Number,
e Hosnita	within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	amination and/or inv	occurred at the time restigation, in my opi	e, date and place, nion, death occurr	and due to the cause ed at the time, date a	(s) and manner a	is stated. e to the cause(s)
Ė	withi To tl	Ž	29b. Signature and title of certifier		29c. License	1/1		Date signed (Mont	
	b		30 Name and address of prison who completed cause of death 5 7 5 7 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	0805 17	right) fickous	Ridse	RdC	lums.	7, 2008
	Sta Registr		DEC 1 9 2008	Signature	and a second				

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) Month 18, Physician 2008 5:45 Αм December Betty Grace Holtschneider /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 215 Antietam Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/07/1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F North Carolina 78 240-38-2896 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or Items 23e or 28e-f show any injury or other traumetic evant, Ite Marical Exeminer Transporce. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No **Funeral Director** Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21221 U.S.A. 215 Antietam Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXXvo Specify: Specify: White Completed by 31 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate PBX Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Ree Eddinger Charles Tate Kivett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2119 Middleborough Road, Baltimore, Maryland 21221 Debra Fishell (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2008 Baltimore, Maryland Oak Lawn Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licenses 232 Part First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) eus Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No ğ 4□Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 1 Tes 2 NO Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 38 403 of death (Item 23a) (Type, Print) 30. Name and add of person who completed cause 5601 Loch Raven Blud Ste 512, Baltu MD. 21239 einor Wa 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

GINAL

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M  1 - State Registrar  Certificate of Death		211111	3 40689
PI	hysicia	an	Decedent's Name (First, Middle, Last)	2. Date of Death	h Day Yea	3. Time of Death
	/Medic	al	4a. Facility Name (If no institution, give street and number)  4b. City, Town, or Location of Death	12	4c. County of De	4
1		C1	Baltimore Rehalilitation Extended care Baltimore		N	14
	neral ector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, OCTOBER		irthplace (State or Foreign Country)
and	×		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	740000	4,7701,791	10d. Inside City Limits
e Maryl	a-f sho iffied at	ctor	MD NA Baltimore			1 DYes 2 □ No
-0036 hours after death with the Maryland	d other tran "natural", or items 23a or 28a-1 snow event, its modical Examiner must be notified at	Director	10e. Street and Number Ave 10f. Zip Code 21215	10	og. Citizen of What C	Country?
death	ems 23 er musi	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Argned Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - An	nerican Indian,
)36 rs after	r, or it	by Fu	1 Never Married 2 Married 1 1 Yes 2 No 1 Yes 7 Specify: 4 No Specify: 4 Year or Dates:	rticari, etc.,	Black, Wh	Black
5-0036 72 hours aft	dical		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ina 1	16b. Kind of Busines	s/Industry
d 21215 filed within 72 Hygiene.	the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Wave noise Mai	nager	Textil	eS
be filed trail Hyg	marked otner imatic event, I	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, M	laiden Surname)	
Maryland d 2 should be file th and Mental H		၉	William Harris  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rure	al Boute Number	City or Town State	Zin Cada)
Ma 2 salith a	other traumatic		Linda Harris - Wife 4527 Homer Av		140. Mi	22215
o e			1 ☐ Burial 2 Cremation 3 ☐ Removal from State   cemetery, crematory or other place)	_   _   _	Baltine	
Baltimore, permit. Pages 1 al Department of Hee	any injury o	i	4 Donation 3 Other (Specify)  21. Sign up of Funeral Service Licensee / 22. Name and Address of Facility	712008 Well F	Junear	) Flore
n goi	E # 8		1 Chun Chinlety How Liberty Ha	hts Aw	e, Balto	MD 21207
Physi	ician	2. 17	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	or respiratory arre	est,	Approximate Interval Between Onset and Death
	dical		disease or condition resulting in death)  a. Due to (or as a consequence of			un Krown
		ē	Sequentially list conditions, if any, learling to immediate cause. Enter Underlying Cause, (Disease or injury			
ecuted	transit	Examiner	triat initiated events C.			
876U, sate be executed	the burial-transit	dical E	Due to (or as a consequence of):			
c 68 ertificat	e as the	Medi	IF FEMALE:			
cords, P.O. BOX 62 requires that the death certific	for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of d Month	elivery Day Year
at the C	stacher	Physi	9 Unknown	7		
dS, uires th	d be de	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4 Vunknown
VITAL KECOLOS, iclan: The law requires t	2 shou	Completed		24a. Was an		utopsy findings available
The T	r, page			autopsy perform 1 □ Yes 2	ed? death?	completion of cause of
VIII /siclar	directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  26. Place of Death Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hot		nce 6 □Other (Sp	
In OT Ing Phy	uneral o	Certification: To	27. Manyler of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury (Born, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how		ecity)
VISION  Attending er death.	by the fi	ficati	2 Accident investigation   M   1 Yes 2 No   3 Suicide 6 Could not be determined   Suicide   Suicide   Could not be determined   Suicide   28f. Location (Stre	eet and Number or F	Rural Route Number	
ital or its after	led in t		4 Homicide Sullding, etc. (Specify)	City or Town,	State)	
DIVISION Of VITAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  With Funeral Director After this conflicted has been signed by the state.	etely fil	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	te and place, and du	e to the cause(s)
To the within	comp	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mor.	th, Day, Year)
		-	20 Name and address of access who consists of water (New 2001)	0) 1	2 15 0	8
'	l		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John S. Lich M.D. 3900 Loch Raven Boulevayd, Baltimore	maryland	121218	
R	Stat egistra		29b. Signature and title of certifier  29c. License number  3+359(6Hi  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John S. Lich M.S. 3900 Loch Raven Boulevayd, Baltimore  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Hallida Month Year **Physician** Mae Barbara ecember 200% /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign (Country) **Funeral** 1 □ M 2 € F Months Days Hours Min 231-36-5780 SO Yrs. North Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No **Funeral Director** anham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Meonee. Elementary/Secondary (0-12) College (1-4or 5+) bmemaker lo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allendale St Balto, MD 21229 tolliday daughter Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other r 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 12/20/08 nudon tark Cemetery 4 Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses Fureral 22. Name and Address of Facility Homo 4600 Balto MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** preumini disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed pti c the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □Yes 20 Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100mstr 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DMQ5

31. Date filed (Month, Day,

915

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** 11:15 PM Mary Mae Ha1e December 16 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimaire Hospital of Baltimore If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 □ M 2 F 80 216-24-5306 MD 02-27-1928 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 209 Water Fountain Court Unit 101 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Item 27 Is marked other than "nature other traumatic event, the Medical 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "I any injury or other traumatic event; the Med any injury or other traumatic event; the Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick S. Hillary Laura L. Sheppard ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Laurie Radford / Daughter 8532 Main Avenue Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12-19-2008 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton\_Funeral & Cremation Srv Glen Burnie, MD 1 2nd Avenue SW 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequent of): disease or condition resulting in death) /Medical Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be execut Failure Due to (or as a consequence of): HOART and burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ No. Fibrillation 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a, Was an cate has l certificate the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ို After this funeral 27. Manner of eat Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation Injury within 24 hours area control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 16, 2008 Res- occ MP 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI Hespital of NAVID NOUR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 DEC 1 2008 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Mai		Certificate		ia wierkarriy	Reg. No.	
	Physic /Medi		1. Decedent's Name (First, Middle, La	1/	Sr.			2. Date of De Month	Day	3. Time of Death
-	Exami		4a Eacility Name (If not institution, give		dical Con	ter Glen	Burnie,	Death MD	4c. County of	
	Funeral Director		5. Social Security Number 6. S 219-18-4686		'In yrs. last birtl Y		Year If Under 24	Min. 8. Date of Big (Month, Da Sept.		B. Birthplace (State or Foreign Country) Maryland
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne An		oc. City, Town Pasade					10d. Inside City Limits 1 □ Yes 2 🎽 No
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 766 221st Street			10f. Zip (	Code 21122		10g. Citizen of Wh	at Country?
9036	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Modical Evaninar cust be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No}\) If Yes, Give Year or Dates:	er in U.S.	13. Was Decede If Yes, specif 1 ☐ Yes 2		n? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. white
15-0	in 72 hc	Completed	15. Decedent's E (Specify only highest gra	ade completed)	16a.	Decedent's Usual (Give kind of work life, DO NOT use	Occupation done during most of retired)	f working	16b. Kind of Busi	ness/Industry
212	e filed within al Hygiene. other than "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		chinist			Calvert	Distillery
Baltimore, Maryland 21215-0036	should be file nd Mental H marked oth imatic even	To Be	17. Father's Name (First, Middle, Last, James		thorn	Sr.	18. Mother's Anna	Name <i>(First, Middle</i> F	Maiden Surname) uller	
Mary	she mand		19a. Informant's Name/Relationship (					or Rural Route Numb		ate, Zip Code)
re,	s 1 and 2 of Health Item 27 Is other tra		Elizabeth C Hent 20a. Method of Disposition			766 221st Disposition (Name crematory or oth		Pasadena M	D 21122 20c. Location - Ci	ty or Town, State
timo	permit. Pages 1 Department of H Important: If Ite any Injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		aven Cem	etery 12	/20/08	Glen Bur	nie MD
Bal	Depar Impor any Ir		21. Signs ture of Funeral Service Licer	nsee			Address of Facility Ountain Ro	Stallings oad Pasade		
	Physician /Medical Examiner		23a. Part I, anter the disease, or om shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	e. Acute	0-	atory D	of dying, such as ca	rdiac or respiratory a	_	Approximate Interval Between Onset and Death
V.	rtificate be executed ng physician and as the burlal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Du (f. (or as a co	onsequence of	r neumo	ni~			l days
68760,	icate be physicia the bur	Medical		d						
	ng as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p  1  Live birth 2  4  Pregnant at tin 9  Unknown	Fetal death	3 ☐ Ectopic pre			23d. Date of Month	,
ords, P.	w requires that is been signed by should be detail	þ	Part II. Other significant conditions of	ontributing to death but n	ot resulting in t	the underlying cau	ise given in Part I.	23e. Did t		ute to the cause of death?  ☐ Probably 4 ☐ Unknown
Division of Vital Records,	נט מל כע	• Completed	25. Was case referred to medical					1 □ Yes	prior prior prior dea 2 No 1 🗆	re autopsy findings available or to completion of cause of th? ]Yes 2 □ No
of Vi	hysicia this cert	To Be	examiner? 1 ☐ Yes 2 No	Hospital: Impatient	2 🗆 ER/Outp	patient 3 DOA	Other:	Death (Check only only only only only only only only		(Specify)
ono	nding P ith, :: After i e funera	ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye	ear) 28b. Tir Inji	me of 28d ury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe I	now injury occurred	
=	I or Attendi after death, Director: /	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farn Specify)	n, street, factory, c	office	28f. Location (S City or Toy	Street and Number on, State)	or Rural Route Number,
_	To the Hospital or Attending Physician: The inwithin 24 hours after death, To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifying Ph	yslcian: To the best of miner: On the basis of ex	amination and	death occurred at or investigation, in	the time, date and p	place, and due to the occurred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	end manner stated	•	29c. l	License number		29d. Date signed (M	
	,	-	Vacin In	Men	- (I) - (A) \ (T		68240		Decembo	r 16,2008
	4		Vadim Korkhov		ospita	Drive	e, Glen	Burnie,	MD 2	~ 16,2008
	Sta Registr	7.6	31. Date filed (Month, Day, Year)  DEC 1 9 20	32. Registrar's	Signature	Lank :	- 1			

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:35 A M Gregory Johnson accompa /Medical or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. las If Under 1 Year 5. Social Security Number **Funeral** Days Min Country) Maryland 1**X** M 2□ F Jan 6, 50 Director 217-68-1659 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 434 Cumming Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. black. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) delivery person charities 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester Johnson Katie Lee McCullough ပ 19a. Informant's Name/Relationship (Type. Print) Chester Johnson/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2623 W. Belvedere Ave #1C Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 $\square$ Burial 2 $\square$ Cremation 3 $\square$ Removal from State 4 $\square$ Donation 5 $\square$ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Lice Conald S Wad, Director m Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine (ena Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 npatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

and Box 68760, attending physician The law requires that the death certificate be P.0. Division of Vital Records, been : has certificate e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica

burial-tran the as 01 signed by the a d be detached for completely filled in by the funeral

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Mexical Exymitmer must be a collected as

Baltimore, Maryland 21215-0036

6 ☐ Could not be 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and title of certifier 29b. Signature,

29c. License number

29d. Date signed (Month, Day, Year) 103

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State Registrar

32. Registrar's Signature

and manner stated.

To the I within 2 To the I

			State of Ma I Items 16	ryland / Depa b, 19a per <i>Cel</i>	artment of H sa, 2887 tificate of 1	61727709 Death			08	40694
Physic		1. Decedent's Name (First, Middle, Last)  David H. Johnson					2. Date of Dea Month Decemb	Day	2008	3. Time of Death 2:00 AM M
/Medi Exami		4a. Facility Name (If not institution, give s	_		4b. City, Town, or			4c. County		
Funeral		12315 Wake Forest  5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year	sville If Under 24 Hrs		1	vard 9. B <u>i</u> rthpla	ace (State or Foreign
Director		424-72-6937	M 2□F	58 Yrs.	Months Days	Hours Min.	Jan 23	1950	Alah	oama
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			····	10	d. Inside City Limits
e Man 3a-f ah	ctor	MD Howard		Clar	ksville					1 ☐ Yes 2√2 No
with th	Dire	10e. Street and Number 12315 Wake Forest	Road		10f. Zip Code 2102	.9		10g. Citizen of	What Count JSA	ry?
paritimities, Mary fighting 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, its Medical Exemican must be notified at any pince.	by Funeral Director	11. Marital Status 1  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2🏋 No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ce-America ck, White, e	etc.
d within 72 hours aft giene. or than "natural", or tra Medical Exerci-	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired mathemati	during most of wo )	rking	16b. Kind of B	vernme	ent
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Menta Menta Merked arked	70 B	David Howard John	son				Pemberto			Ta .
INCL YICLICA d 2 should be file th and Mental Hy 17 is marked oth traumatic avent	1	19a. Informant's Name/Relationship (Type Marilyn Johnson/	spouse-		ng Address (Street a 5 Wake Fo					Code) 21029
Definition C;  bermit. Pages 1 er Department of Heal mportent: If Item 2 any Injury or other page.		Marlyn Johnson - St 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 ☒ Donation 5 □ Other (Specify)		20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)   	Date	20c. Location	- City or Tov	wn, State
permit. Departn Imports any inju		21. Signature of Funeral Service Licenses	adellire		Name and Address ate Anato	_		Baltim	ore S	treet
Pnysician /Medical Examiner		23a. Part Enter the disease, or compli- shock, or heart failure. List only on trimediate Cause (Final disease or condition resulting in death)	e cause of each line	1. 1. 1	er the mode of dyin				1	Approximate Interval Between on et and Death
ificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):						
death cert a attendin d for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
quires that the an signed by the uld be detache	<u>م</u>	Part II. Other significant conditions con	tributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	-		e cause of death? ably 4 Unknown
Invision of vital necolus, if or Attending Physician: The law requires tells death. Director: After this certificete hes been signified by the funeral director, page 2 should be	Completed	- ' '					24a. Was a autop perfor 1 \( \t \) Yes	med?		sy findings available pletion of cause of 2□ No
sician s certifi lirector	o Be	25. Was case referred to medical examiner?  1 Tyes No	ospital:	t 2 ☐ ER/Outpatier	nt 3□ DOA Othe	or	ath <i>(Check only o</i> d Iome <b>X</b> Resid		nas /Cnanh	1
nding Phy ath. r: After this e funeral o	<b> </b> -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Work		28d. Describe h			
To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
Hospi 24 hou Funar nely fill	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of ter: On the basis of and manner state	my knowledge, deatlexamination and/or in	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	e, and due to the durred at the time, d	ause(s) and m late and place,	anner as sta and due to	ated. the cause(s)
To the within To the comple	Med	29b. Signature and title of certifie	)		29c. License	e number	211	29d. Date signe	ed (Month, D	Day, Year)
		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	P6010		3145	(	21	11/6
12		HEVIND DE-	SAI	7 45,	27417	AL -	DR. L	1 N	THI	CUM
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registra	r's Signature						

DHMH 17 Rev 1/2001

			For State	State of Marylan	d / Department <i>Certificate</i>			the to William	10595
			Registrer  1. Decedent's Name (First, Middle, Last)	P1 1	Certificate	- OI Dealii	2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic	al		(Tladys	Isabell		son December		<u> </u>
	Examin	er	4a. Facility Name (If not institution, give str	villy Cente		rown, or Location of Di	e ·	N/i	7
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) If Under Months		lin. (Month, Day, Yee	9. Birt	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	, ,	//		NOV. 28, 1	7021 1910	10d. Inside City Limits
	arylan show	ō	10a. State 10b. County	10c. City	7, Town or Location Baltimore	2			19 Yes 2 □ No
	h the N r 28a-f	irect	10e. Street and Number	^	10f. Zip		10g. C	Citizen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	3320 Benson	. Was Decedent Ever in U.	S 13 Was Deced	2 ( 22 or Hispanic Origin'	(Specify Yes or No-	14. Race - Ame	erican Indian,
036	be filed within 72 hours after death with the Marylan tal Hygiene. Id elyygiene death with Institutel; or liems 23a or 28a-f show other than "natural; or liems 23a or 28a-f show event, Its Mardical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, spec	ent of Hispanic Origin ify Cuban, Mexican, P INO Specify:	uerto Rican, etc.)	Black, Whit	e, etc. Wack
15-0036	"natur	leted	15. Decedent's Educa (Specify only highest grade of	tion :ampleted)	16a. Decedent's Usua (Give kind of work life. DO NOT us	k done during most of		Kind of Business	/Industry
717	be filed within 72 tal Hygiene. d other then "ne event, It a Wedic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	4	acher		Educ	ation
and		To Be C	17. Father's Name (First, Middle, Last)	VI'S		18. Mother's	Name (First, Middle, Maide 24e Lou	en Sumame)	
Mary	and and series		19a. Informant's Name/Relationship (Type		19b. Mailing Address	Street and Number of	Rural Route Number, City	or Town, State,	Zip Code) MD 21163
	s 1 and 2 if Health itam 27 other tra		20a. Method of Disposition		lace of Disposition (Name ametery, crematory or of	ne of		Location · City or	
Baltimore,	nit. Pages vartment of ortant: If it injury or o		1  Perial 2  Cremation 3  Rei '4  Donation 5  Other (Specify)	noval from State	rbutus Co	metery la	2/22/08 F	3altimo	re, MD
Ball	permit. Pages Department of I Important: If its any injury or o'		21. Signature of Funeral Service Licensee	Insel Se	22. Name and	d Address of Facility Liberty	Howell I-W	Balto.	Hone 21207
, 1			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death		4	diac or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	rement	12			years
	Examiner		Sequentially list conditions, b.						
7	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
0,0	e exection and unial-tra	Exa	that initiated events coresulting in death) Last	Due to (or as a conseq	uence of):				
68760	ficate by physic is the b	edical	d.	- C- H-					
Box	ath certi tending or use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna	I death 3 Ectopic pr			23d. Date of de Month	livery Day Year
P.O. E	the dea by the a	nysici	1 ☐ Yes 2 M No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5 ☐ Other (sp	ecify)			
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by Pł	Part II. Other significant conditions control		ulting in the underlying c	ause given in Part I.	23e. Did tobacc	11	o the cause of death?
Vital Records,	law req as beer 2 shou	Completed	Hypertension				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
alB	n: The ficate h r. page		Cinemia			00 Blass of	performed	? death? No 1 ☐ Ye	
Ţ	ysicial Ils certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1   inpatient 2	ER/Outpatient 3 DC	Tan a	Death (Check only one) ng Home 5 🗆 Residence	6 □Other (Sp.	ecify)
o uc	ding Pt	lon	27. Manner of Death  1 DiNatural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 2 Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
Division of	or Attantiter deat irector: n by the	Certification:	Accident investigation    Accident investigation	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, factory fy)		28f. Location (Street City or Town, St		Rural Route Number,
	lospital ( I hours a cunaral C		29a. Certifier Certifying Physi	cian: To the best of my kno er: On the basis of examina	owledge, death occurred	at the time, date and p	place, and due to the cause occurred at the time, date a	e(s) and manner a and place, and du	us stated.
	o the hithin 24 o the Formplete	Medical	29b. Signature and title of certifier	and manner stated.	-	1	224	Data signed (Mass	nth Day Voor
	- s - ŏ			with	0	D5539	1 De	cember.	16,2008
	10		30. Name and address of person who con	poler scuse of death (Iter	m 23a) (Type, Print)	Baltin	De nore, Man	culand	21227
	Sta		31. Date file (Month, Day, Year)	32 Registrar's Sign	ature A	,	1 1 100	1	1
	Regist	rar	necl 9 2008	Add Ales A	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day Year Katle Johnson 0900 AM 12 4 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arlington 1-timore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Sex 1 □ M 2D F Days Months 12-8917 100 May 13, 1908 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Examiner must be notified at 1 Yes 2 No **Funeral Director** MI) partimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA selvie 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 Specify: Black Baltimore, Maryland 21215-0036 Be Completed by Specify 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave Baltimore Belvieu Nelson MD 21215 niece 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 18/08 NOOdlawn Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service License 22. Name and Address of Facility -cureral -westy Harts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intracrunial hemorrhan weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 🗆 Ectopic pregnancy detached for Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed?

1 Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours atter deatl the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 043386 457 12.17.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ELLW

Place

Bullivora

21217

1714

32. Registrar's Signature

1.toward

08-09363 John Bernard Jones

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death			Reg	. No.	200	8 4069
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd	. ,	-				Mo	ite of Death onth	Day	Year	3. Time of Death 1246 hrs
viedicai Exami	ilei	John Berna  4a. Facility Name (if not institution)			1 41	o. City, Town, or L	ocation of [		cember		08 ounty of Death	1246 FITS
		6159 Rockburn Hill R			"	Elkridge				How	•	
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birt	hday)	If Under 1 Year	If Under 2		ate of Birth	(MM/DD/	YYYY) 9. Birti	nplace (State or Mary Land
Director		217-64-7017	1X M 2 F	53	Yrs.	Months Days	Hours	Min. Ju	ıly 24	, 19	)55 Col	intry)
, yr		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locatio							10d. Inside City Limits
d 10w al			imore	,								1 Yes 2 X No
arylan 8a-fsl	cto	Maryland   Balt	IIIIOLE	Gwy	nn Oa	10f. Zip Code			100	g. Citizen	of What Coun	
the Man or 2	Dire	1139 Ingleside	Avenue			21207	7			US		
5-0036 led within 72 hours after death with the Maryland Hygiene. I other than "uatural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status	12. Was Decedent			Decedent of Hisp				14.		can Indian, Black,
ter death w	Fun	1 X Never Married 2 M	1 Yes 2	X No		s, specify Cuban,		TUELLO RIGALI	, etc.)		White, etc.	
us afte	à	Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates:	pleted) 16a		Yes 2X No s Usual Occupation		nd of work d	one I		ec <i>ify:</i> Whi	
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life.			0.1.0	TOD: TAITO	or Dadinocon	idddiy
036 vithin ene. ir than	dm	10			Med	chanic				A	Automob	ile
15-C filed v Hygi d oth		17. Father's Name (First, Middle	•			1		Name (First				
21215-0036 hould be filed within 7 ad Mental Hygiene. is marked other than ttie event, the Medica	To Be	John P. Jones  19a. Informant's Name/Relations		19	b. Mailing	Address (Street		raldir				Zin Code)
		Linda A. Mart				Martlock						
ore, "M es 1 and 2 of Health If item 2 her traum		20a. Method of Disposition		20b. Place		ion (Name of cem		Date			ation - City or	
Page ent		1 Burial 2 X Cremation 4 Donation 5 Other Si	n 3 Removal from Sta	10	•	natory In	nc. 1	12/18/	/08	Balt	imore.	Maryland
Baltir permit Departin Importa		21. Signature of Funeral Service	Licensee		22.	remation	of \$001	ety Of				and 21228
	-	Thomas Gregor  23a. Part I. Enter the disease, or		the treath Do no								
Physician /Medical	ļ	failure. List only one cause	on each line.	U					-	it, SHOCK,	or neart	Approximate Interval Between Onset and Death
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		Sequentially list conditions,	b									
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760, ficate be g physicis the burit	/Medical	IF FEMALE:	23c. If yes, outcom	ne of pregnancy						23d. D	ate of delivery	
687 ertific. ding p	lan/I	23b. Was decedent pregnant in the past 12 months?	ne 1 Live birth	2	Feta	al death 3	Ectopic p	regnancy		1		ay Year
Box 68 e death certifi the attending ed for use as	Physiciar	1 Yes 2 No 9 Uni	Known g Unknown	time of death	Oth	er (Specify)						
		Part II. Other significant condit		but not resulting	g in the un	derlying cause giv	ven in Part	l. 2	23e. Did tob	acco use	contribute to t	he cause of death?
P.O.	d b				_			_	1 Yes	2 🗸 No	o 3 Prob	ably 4 Unknown
Division of Vital Records, Ital or Attending Physician: The law requires rs after death.  "In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							2	24a. Was ar			opsy findings available ompletion of cause of
Reco The law cate has	E								✓ Yes 2		death? 1 ✔ Ye	
ital Recionant The sectificate rector, page	Be	25. Was case referred to medica examiner?						heck only o	ne)			
f Vil	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		utpatient	o Dox		Nursing Hon			6 V Other	Scene
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'isio	icat	2 Accident Inves	stigation 28e Place of Ini	urv - At home, fa	arm, street	, factory, office bu	Listeners I		ocation (St	reet and I	Number or Rur	al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		d not be rmined (Specify)			•	<b>0</b> ,		or Town, Sta			, 2,
Hosp 24 ho Func etely f			hysician: To the best of my									
To the Hos within 24 h To the Fur completely	Medical		miner:On the basis of exam and manner stated.	nination and/or in	nvestigatio			rred at the t				
	Σ	29b. Signature and title of certifie	er V			29c. License					e signed (Mon	
		Mayone 1	The Still	and the second		O.C.M	1.⊑.			Decem	nber 14, 20	U0
		<ol> <li>Name and address of person Margarita Korell MD.</li> </ol>	Assistant Medical	, ,	111 Pe	nn Street, Ba	ltimore. I	MD 2120	1			
	ate	31. Date filed (Month, Day Year)	32. Registrar	's Signature	A	All a						
Regist	rar	DEC I	9 2008	W St	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14,2008 12:05PM Day **Physician** December Florence Krauss /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Marley Neck Nursing Home Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-16-1929 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 X 79 Director 578-36-9796 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show Baltimore 1 ☐ Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be USA 120 Haile Avenue 21225 death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Healthcare 12 Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H fitem 27 is marked otf ir other traumatic even Edna Stebbins Alfred Stebbins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Latoza- Granddaughter 120 Haile Ave., Baltimore, MD 21225 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition o ... 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Department of Important: If any injury or once. Bayview Crematory 12-16-08 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bradley-Ashton FUneral Home 2134 Willow Spring Road, 21222 PA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Immediate Cause (Final disease or condition resulting in death) Hmy time Physician walas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a dunsequency of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably # Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has be irector, page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 22 No 4☐ Mursing Home 5☐ Residence 6 ☐ Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-15-68 P57028 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue #231 Annapolis Ridgely Chapra m.D 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 19 2008 Registrar

Registrar
DHMH 17 Rev 1/2001

**OCME 2006** 

State

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 17, 2008

Laron Locke MD

31. Date filed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

			Please Type or Print in Black In		-	_	
			1 - State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and N rtificate of Death	Reg	ene 2008	50700
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ada Louise Kincaid		2. Date of Death Month December	Day Year 11, 2008	3. Time of Death 8:15 A. M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
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н	Funeral Director		214 46 0198 1 D M 2 1 R 83 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Cour	t Virginia
	D		Usual Residence of Decedent		04/04/1		
	urylan show	_	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ba-f	Director	Maryland Anne Arundel Pasade		100	g. Citizen of What Coun	
	with t	直	9 S. Ritchie Highway	10f. Zip Code 21122	100	U.S.A.	nu y r
	ns 23	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	an Indian,
9	after o	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 <b>X</b> No <i>Specify:</i>	Rican, etc.)	Black, White,	etc.
933	ours a	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Till tes Ziguno Specify:			ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Exprimer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Ind	dustry
172	withir iene. than	dwo	Flementary/Secondary (0-12)   College (1-4or 5+)	nemaker		Own Home	
	il Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience must be notified at once.	To E	Wilbur Clarence Vano	lall Mar	y Lenora	Sifers	
lar	2 sho and is ma			ng Address (Street and Number or Run			
6,7	1 and Health em 27 ther t		Sofee magner / Daughter	oint Pleasent Road		urnie, MD 2	
nor	ages int of l t: If ite		Taburial 2 Cremation 3 Hernoval from State	matory or other place)			
Baltimore,	artme artme ortani injury				-/	Baltimore, cal Service	
Ba	permi Depar Impor any ir			4001 Ritchie Highw			
	Dharisis		23a. Part 1. Enter the disease, or complications that caused to death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ter the mode of dying, such as cardiac		_	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of):	W/ HE 1003 CZO 100	110 31.	301130	YEARS
	Examiner	_	Sequentially list conditions. b.				
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
120.	execut and al-tran	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
760,	eath certificate be executed attending physician and for use as the burial-transit		C <sub>d</sub>				
6876	rtificar ng phy as th	Physician/Medical	IF FEMALE:				
Вох	ath ce ttendi or use	an/l	23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delive	ery Day Year
0.	ne dea the a	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		World	Day
ο.	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
Vital Records,	luires n sign lld be	d by			1 ☐ Yes	2 ☐ No 3 ☐ Prob	pably 4 Unknown
Ö	w requir s been s should	lete			24a. Was an	24b. Were auto	psy findings available
æ	The la	Completed			autopsy performe 1 □Yes 2	ed? death?	mpletion of cause of 2 □ No
ita	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)	5.10	
of V	hysic this co	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 ☐ Other (Specif	(y)
n C	ding F	ion:	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	death ctor: y the	licat			28f. Location (Stre	et and Number or Rura	al Route Number.
Οį	al or A safter I Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal manner: On the basis of examination and/or in and manner stated.				
	o the ithin i	Mec	29b. Signature and title of celtifier	29c. License number	290	d. Date signed (Month,	Day, Year)
	F > F 0		I call - Ithis.	D29807	1	2/11/08	7
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		, , , ,	
	Ú			S.CRAINHWY GL	EN BURN	ITE MS:	21061
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	7200			
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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			,		Certi	ficate of	Death		Reg. N	200	3 40	101
			1. Decedent's Name								2. Date of I	Death	Yan Yan	3. Time of	Death
:11	Physici /Medic		Thomas To	wnsend	Keller I	II					Decemb	er Ĭ	5 2008	4:30	РМ
	Examin		4a. Facility Name (If Suburban			mber)			Bethes			M	c. County of De Iontgome		
	Funeral Director		5. Social Security No. 579–36–87	736	6. Sex 1 X M 2 □ F	7. Age (In yrs 76	s. last birt	Yrs.	f Under 1 Year Months Days			Birth Day Yea 11,	<sup>r)</sup> 1932 Wa	irthplace <i>(Stat</i> e o Co <i>untry)</i> ISNINGTO	or Foreign n DC
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town	or Locat	ion					10d. Inside Ci	ity Limits
	Maryl -f sho	tor	Maryland	Montgo	mery	Sil	ver	Spri	.ng					1 □ Yes	
	h the	irec	10e. Street and Num	nber		1		İ	10f. Zip Code			10g. C	Citizen of What C	Country?	
	th wit	ralD	3600 Gler	neagles	Drive,	₹2B			20906			Uni	Lted Sta	tes	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentral Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic event, If a Modical Examination and Injury or other traumatic events.	by Funeral Director	11. Marital Status  1 □ Never Marrie 3 □ Widowed		Armed Fo				s Decedent of es, specify Cub ]Yes 2∭No	Hispanic Origin? ( ban, Mexican, Pue Specify:	Specify Yes or I to Rican, etc.)	No-	14. Race - An Black, Wh Specify: W		
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ğ	al Hyg	Be C	17. Father's Name (			_				18. Mother's Na			en Surname)		
<u>a</u>	Ment Ment arked aric e	To	Thomas To	wnsend	Keller,	Jr.				Dorothy	Squire	S			
Baltimore, Marvland 21215-0036	and 2 she ealth and n 27 is m		19a. Informant's Na Karen E.	Keller			16	12 1	5th Str	eet, NW,	#4, Wa	shin	gton, D	C 20009	
imore	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disp 1 ☐ Burial 2 ☑ 4 ☐ Donation	Cremation	3 ☐ Removal from	State Mor	Place of cemeter Tgome	Dispositi y, cremat ery Cr	on (Name of ory or other pla ematorium	Dece	mber 17 08	Bet	hesda,	r Town, State Maryland	1
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between												
	Physician		Immediate Cause (I	Final n	- a.	5	EP	515						Onset and I	Death
	/Medical Examiner		resulting in death)	10	Due to	(or as a conse			1.0						
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9 ×	eath certific attending p		IF FEMALE:		23c If was ou	tcome of pregr	nancy								
% [. .0. Bo	D 0 D	Physician/	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live	birth 2 Pet nant at time of	tal death		ctopic pregnan ther (specify) _	су			23d. Date of d Month		Year
2 (15/08	ires that signed t	by P	Part II. Other signifi	cant conditio	ns contributing to d	eath but not re	sulting in	the unde	rlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of d	leath?
ord	w requir been s should	ted	-								1	]Yes :	2 <del>                                    </del>	Probably 4 ☐ U	Jnknown
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homas on of Vita	ding Phys h. After this funeral dir	<u>ان</u>	1 Yes 2 14 27. Manner of Death		28a. Date	Inpatient 2 of Injury	28b. T	ime of	3 DOA 28c. Inju	ner: 4  Nursing l	Home 5 ☐ Re 28d. Describ			ecify)	
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	To the within comp	ž	29b. Signature and t	itle of certifier	7 1				29c, Licen				ate signed (Mor		
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_	10+1		30. Name and addre	o, M.D	., 10110	Molecu:	lar I	Drive	e, #206	, Rockvi	lle, Ma	ry1aı	nd 20850	)	
	Sta Registr	_	31. Date filed (Monti	1, Day, Year) 1 9 20	308	Registrar's Sign	nature		A. Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Carrier and Car						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Wilbert Krammer 9:28 PM December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPital Baltimore N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 219-22-7509 **Director** 81 July 01 1927 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any infury or other traumatic event, the Medice Exercition on other traumatic event, the Medice Exercition of the country. Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Siske 21226 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Auto Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbert John Krammer Sr. ပ Grace Rose Grahm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarice M. Krammer (spouse) 1010 Siske, Baltimore, MD 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. Date 19 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Maryland Veterans Cem 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 disease, or comp a lure. List only o cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Enter the shock, or heart fa Immediate Cause (Fin pneumonia **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septicemi Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit COPD Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 DUnknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Director; 3 Suicide 6 Could not be determined 28e. Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES DD1 12,13,2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harbor Hospital, 3001 S Hanover Street, Baltimore, 21225. MD May Alattar. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month Inthoni . Nec 10:50 A M nd 6 give street and number) 4a. Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death Way OREST Hartord 8. Date of Birth (Month, Day, Year)
April 28, 1921 Wisconsin If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F rs. last birthday) Birthplace (State or Foreign Country) Security Number 7. Age (In y Days Hours Months 396-10-1838 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2X No Maryland Forest Hill Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 212 Cartland Way 21050 12. Was Decedent Ever in U.S.
Armed Forces?
1½ Yes 2 □ No 1942—
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify:White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Telecommunications Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto N. Lind Clara Nerison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Cartland Way Forest Hill, Maryland 21050 Karen Brauer / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dec. 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel-Forest Hill, Maryland Bel Air Zuwe

Name and Address of Facility

Evans Funeral Chapel & Cremation Services-Bel Air

Forcet Hill. Maryland 21050 2008 21. Signatur Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inso a 0 years WY Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the charge Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☎No 24a. Was an autopsy 2 No 1 Tyes 26. Place of Death (Check only one. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at once.

Baltimore, Maryland 21215-0036

sician and burial-trans cate has been signed by the attending physician page 2 should be detached for use as the buria certificate

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician: 7 24 hours after death. Funeral Director; After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 641

Physician/Medical <u>≨</u> Completed

State Registrar

25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1/4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1737016 Occamber 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Checks St, Sete 4,05, B. Huer, No 21204 puhe in m.

(veen,

31. Date filed (Month, Day, Year) DEC 1 9 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARGARET LOGUE 2008 22.8 5 /Medical 4a. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SALTIMONE MOD C-000 SAMALITAD HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 💢 F Director 218-42-9625 April 2, 1920 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Evaminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1XYes 2 □ No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6918 Chambers Road 21234 by Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer B. Holland ပ Barbara L. Gunther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1933 Jordans Retreat Road New Windsor, MD 21776

Co of Disnosition (Name of Date 20c. Location - City or Town, State <u> Barbara Achziger - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery | 12/19/2008 Rosedale, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Parkville
8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee 101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYUCARNIAC INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to himme hate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760,5 Due to (or as a consequence of): attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 37 KVC TLUN 0 % 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown JANI TE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 DM within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified DECLIM 2008 04>945 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WICH NAVEN BIND DA JIMONE HAM 5601 MAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** iRainia /Medical Facility Name (If not institution, ove street and number 4c. County of Death Examiner Baltimore Birthplace (State or Foreign Country). **Funeral** 1 ☐ M 2 😿 F Min Months Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Eventhant" and the notified at 1 ☐ Yes 2 ☑ No Director 10e. Street and Numbe 10a. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No altimore, Maryland 21215-0036 Specify. Specify: Black þ 3 ₩Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mcechandisc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, ate, Zip Code) (Geard-daughter) 5876 Dock Ridge in Elkeidge, MD 21075 Place of Disposition (Name of cemetery, crematory or other place) 20b. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Quah C. Gloone 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mphoma disease or condition resulting in death) //Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant in the past 12 months? If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mort Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate ha 1 ☐ Yes 2 [ 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) nospice Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify Cin-patient Certification: To filled in by the funeral of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) DEC 1 9 2008

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Japakeno 25 Main, Suife 200, Reisterstown, MD. 21136 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:42 M John Joseph Lentz CEMBE 200 8 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner ALTIMORE A GNE **Baltimore City** If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 79 MD Director 213-26-6125 Sep 27, 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show udical Evanithed at 1 □Yes 2 No Director West Friendship MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21794 U.S.A. 3285 Rosemary Lane Funeral 12. Was Decedent Ever in U.S. Atmed Forces? 1 XYes 2 ☐ No IfYes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: \$ White 3 Widowed 4 Divorced Year or Dates: Completed er than "natura", the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ith and Mental Hygiene.
27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Engineer **US Government** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Peter Lentz Helen Marie Brannan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a if item 27 is or other tra Gary Peklo Personal Rep. 3685 Park Ave. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 □Removal from State Dec 17, 2008 4 Donation 5 ☐ Other (Specify) Sykesville, Maryland All County Cremation Services, 22. Name and Address of Facility Sign Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final **Physician** 4 years METASTATIC PROSTATE CARCINOMA bease or condition sulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consoluence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-transi Exami or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 T Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐Yes 2**A**No Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 2008 D 226 4F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Jerome I SNYDER M.O.

Year

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

900 SOUTH CATON AVENUE BALTIMORE MARYLAND 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:32 PM Sally Mae Lowe Dec 15, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge Howard 8013 Glasgow Ave If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 218-68-2479 Days 1 □ M 2 🕽 F Yrs. Director VA Apr 16, 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 □Yes 2 No Director Elkridge Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A Completed by Funeral 8013 Glasgow Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMENIA or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ **Ernest William Deavers Ettie Frances Walker** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 8013 Glasgow Ave Elkridge, MD 21075 Pamela Lowe Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 19, 2008 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Signature of Funeral S 22. Name and Address of Facility vice Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type)

1 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Louis Joseph Libertini 2008 December 9:44 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll Sex 11XXM 2□ F 8. Date of Birth (Month, Day, Dec. 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Year) Days Hours 65 Yrs **Director** 1943 Maryland 218-40-2601 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show it than "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with United States 2805 Bel Court 21102 America Funeral of 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married XX Married 1 ☐Yes ŽÍXNo If Yes, Give Year or Dates à Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 I.T. Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Francis Libertini Isabella Colacce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau once. Margaret T. Libertini (Wife) 2805 Bel Court, Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 □ Donation (5 □ Other (Specify) Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** HSC UT disease or condition resulting in death) / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Vasiula/ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown plnods Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 : autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examine? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 es 2 🗆 No Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Naturai Injury 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

P.O. Division of Vital Records. the Hospital or Attending Physician: 흔

Maryland 21215-0036

Baltimore,

Box 68760

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) DEC 1 9 2008

Herbert

P. Hende MC 32. Registrar's Signature course

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** boember 2008 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Montgomer VOSS Hospita DVIN 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 525-41-1019 **Director** Drea Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28a-f show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exemple must be retified at 1 Yes 2 No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 KINO Baltimore, Maryland 21215-0036 Specify: ASIQN Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kee omestic 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 00n 000 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 single beauth an Important: If item 27 is any Injury or other trausones. Blvd Baltimore, MD 21239 6401 20a. Method of Disposition

1 Burial 2 Cremation 3 R

4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State Baltimore, 21. Signature of Funeral Service Licensee Howell Funcial 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 No
9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐No investigation To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Ca (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Glen Rd, 1011 a 32 Registrar's Signature 31. Date filed (Month, State Coil.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 14,2008 Joseph Bryant Marchant, Jr. 4:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☑ M 2 □ F 0 Director Dec. 14, 2008 Maryland N/AUsual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 7.1s marked other than "natural", or items 23a or 28a-f show traumatic event, It-e Medical Examinating the notified at Director Parkville 1 □Yes 2√No Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 3340 Willoughby Road 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Megan Andrea Miller ၉ Joseph Bryant Marchant, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Megan A. Miller - Mother 3340 Willoughby Road, Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Charel of Cremation Syrs.—Belair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dec.17,2008 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licenses Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed CARDIAC FAILURE burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 1 □ Yes 2 1 □Yes 2 □ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

29c, License number

D 44809

DRIVE TOWSON MARYLAND

29d. Date signed (Month, Day, Year)

0

State Registrar 29b. Signature and title of certifier

MOHOMMAD TORAL 31. Date filed (Month, Day, Year)

W4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7671 OSLER
32. Registrar's Signature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:08 A M Margaret Miller December 11, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3714 Woodsdale Road Abingdon Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/22/1921 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F 87 **Director** 220-12-7415 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the "Medical Examinar is ust be notified at Harford Director Abingdon MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3714 Woodsdale Road 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 kno If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No 2 Specify: White 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ith. Ith any once. Elementary/Secondary (0-12) At Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK Lillian Louis J. Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Simone / 7220 Old Harford Rd. Parkville, MD 21234 20b. Place of Disposition (Name of Evans Funeral 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-17-08 Forest Hill 4 □ Donation 5 □ Other (Specify) Chapel- Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licens re Part I. Enter I e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her failure. List only one cause on each line. Approximate Interval Between Onset and Death Image in the condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of 90 0 Physician; The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 pe 1 X es 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? has 52Ri 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **y**4 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Deuth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/12/08

12

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

2801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

d.M

32. Registrar's Signature

Hudson St. Suite A Baltimore, MD 21224

			State of Maryla  State Amend Item 23a  Amend Item 23a  The state of Maryla  State of Maryla  Amend Item 23a  The state of Maryla  The s	nd/D per d	epartment Ir	of Health of Death	and Ment 8dhb	al Hygi Re	ene g. No. 20 (	08 4071	2
	Physicia	an	1. Decedent's Name (First, Middle, Last)  MADY MADCADET MAI COROM				C <sub>N</sub>	2. Date of Death Month Day 14 26		3. Time of Death	Л
	/Medic Examin		MARY MARGARET MALSTROM  a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Examin	Ci	UNION MEMORIAL HOSPITAL			ltimore			N,	'A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 ☐ M 2 ☐ F 86	\	hday) If Under 1 Months	Year If Unde Days Hours	Min. Ju	ate of Birth Month, Day, ne 29	Year) 9	Birthplace (State or Foreig Country) Mary Land	n
			Usual Residence of Decedent		or Location		1 100	110 25,	1722	10d. Inside City Limits	
	/laryla f shov	ō	Maryland N/A		1timore	Ci ty				1 X Yes 2 □ No	
	r 28a-	irec	10e. Street and Number		10f. Zip (			10	g. Citizen of Wha	it Country?	_
	th with	ralD	3100 White Avenue			21214			US	SA	
	er dea items	<b>Funeral Director</b>	11. Marital Status  12. Was Decedent Ever in Married Forces?  1. Types 2. Fill No.	J.S.	13. Was Decede If Yes, specif	ent of Hispanic C fy Cuban, Mexica	rigin? (Specify Y an, Puerto Rican	es or No- , etc.)	14. Race - Black, \	American Indian, White, etc.	
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, its Medical Examination rottified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	X No Specify	y:		Specify:	White	
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pu	tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)		1-2	18. Moth	ner's Name (Firs	t, Middle, M	aiden Surname)		
ryla	should be ind Mental marked o	٩	Francis Leo Malstrom  19a. Informant's Name/Relationship (Type. Print)	106	Mailing Address (		argaret			oto Zin Codo)	_
Ma	and 2 st ealth an n 27 is r ner traur		Frances E. Malstrom (Sister)	1	00 White						
ore,	ges 1 and 2 it of Health If item 27 is or other tra		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of	Disposition (Name y, crematory or oth	e of	Date		Oc. Location - Cit		
ţ	Page Int.		4 □ Donation 5 □ Other (Specify)	ılane						ium, Maryland	1
Bal	permit, Departr Importa any inju		21. Sign W Fuyeral exice 13. Martin D. Lawson		MITCHE	LL-WIEDE	FELD FU	NERAL	HOME, I	NC.	
			Martin U. Lawson  6500 York Road, Baltimore, Maryland 21212  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between								
	Physician		Immediate Cause (Final disease or condition a. Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull Chronichyper april 6   Ull C								
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	ertifica ling ph		IF FEMALE:		-	-					
J. A. Box	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 pronths?	tal death	3 ☐ Ectopic pro				23d. Date o Month		
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As, H	Attending Physician: The law requires that the death certificate be executed reach.  r death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	by	Part II. Other significant conditions contributing to death but not re	1. 2	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown			m			
Sign	w requ	letec						24a. Was an		re autopsy findings available	
Re (	ician: The law certificate has ector, page 2 s	Completed						autopsy perform □Yes 2	/ prio	r to completion of cause of	
Vita	ician; sertific ector, p	Be C	25. Was case referred to medical examiner?  26. Place of Death (Check only one)								
of	ding Physician: h. After this certific funeral director,	:To	1 Ves 2 Logo Hospital: 1 Logo Path 2 ER/Outpatient 2 DeAl Prime of 28a. Date of Injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
ion	Attending death. ctor; Afte y the fune	ation	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Ir	njury M	Work? 1 □ Yes 2 □	□No				
∯ Division of Vital	or Atte after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e, Place of Injury - At building, etc. (Special Could not be determined 28e, Place of Injury - At building, etc. (Special Could not be determined 28e, Place of Injury - At building, etc.)	home, far cify)	rm, street, factory,	office	28f. L	ocation (Stre City or Town,	eet and Number of State)	or Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my king the best of my king and manner stated.								****
	To the within To the Comple	Med	29b. Signature and title of certifier		29c.	License number		29	d. Date signed (A	Month, Day, Year)	
			1 to examps maria	,	A	T2438	5946-8	16	12/14/	30	
	3		30. Name and address of person who completed cause of death (Ite	əm 23a) (		umor	101 1	tain' 1	k.1 D	It was and	1
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	Park I	U/ //U!C	WI (	10 XI	191 D	WILLIAM DE MI	ر
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			For State Registrar	ate of Maryland / [		rtment of H tificate of L		nd Men	, ,	jiene leg. No. 2	102	4.0	713
	Physicia	an	Decedent's Name (First, Middle, Last)     ANNE ELIZABETH M	IRPHY	·				Date of Deat	th	Year 2008	3. Time of	Death A M
	/Medic Examin		4a. Facility Name (If not institution, give street Franklin Square HDSQ	t and number)	,	4b. City, Town, or ROSCARIA	Location of	Death	12	4c. County	of Death	942	7.181
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (	Date of Birth Month, Day, T. 12	Year)		ace (State or ry) MD	
	pui »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Loc	ation			1. 12	, 1/21	10	d. Inside Cit	
	e Marylan Ba-f show	ctor	MD. BALTIMORE	ROS	EDAL	E						1 □Yes	2 <b>X</b> No
	3a or 2	al Dire	10e. Street and Number 1315 CHESACO AVE.,	APT. 303		10f. Zip Code	212	237		og. Citizen of V NITED S			
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mudical Erracinar must be notified at	by Funeral Director	1 Never Married 2 Married	Vas Decedent Ever in U.S. vrmed Forces? □Yes 2★□ No 'Yes, Give' e ar or Dates:		/as Decedent of Hi Yes, specify Cuba □Yes 2 1 No	ispanic Origi In, Mexican, Specify:	in? (Specify Puerto Ricar	Yes or No- n, etc.)		e - America k, White, e		
3215-0036	within 72 ho ene. than "natur	Completed	15. Decedent's Educatio (Specify only highest grade code) Elementary/Secondary (0-12)	nnpleted) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired LTER	ation during most o	of working		16b. Kind of Bu		ustry	
=	be d	To Be Co	17. Father's Name (First, Middle, Last)  JAMES BROWN					s Name <i>(Firs</i> IE JAC		Maiden Surnam	e)		
Mar)	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. F BOB MURPHY/SON			Address (Street a				r, City or Town, 20723		Code)	
9	ges 1 an nt of Hea if item 2 or other		20a. Method of Disposition  1 ABurial 2 □ Cremation 3 □ Remo	20b. Place of		ition (Name of atory or other place		Date		20c. Location -		vn, State	
Бантто	t. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		-	N CEMETE Name and Addres		2/17/0 CHAR	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	BALTIMO ZEILE			
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	Physician /Medical Examiner		23a. Par (1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th										
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	Sta Registra		31. Date filed (Month, Day, Year) DEC 1 9 2008	32 Registrar's Signature	Tual	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	1001	1111101	V 111	- 416	<u>フ I</u>		

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 4:15 A M Janet Tina Mickiewicz December 17. 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Perryville 523 Richmond Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 X F Director 217-58-7517 54 05/20/1954 Massachusetts Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Cecil Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 523 Richmond Street U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item only injury or other traumatic event, the Medical Exercited 2002. Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 217 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bartender Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl E. Shuler Edith Eller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Mickiewicz/Husband 523 Richmond St., Perryville, MD 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 12/17/2008 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CORD END STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, ed by the a detached f cete has been signed by page 2 should be detact certificete has been or Attending Physician: After this certification funeral director. death. Director filled in by within 24 hours after or To the Funeral Direct completely filled in by To the Hospitel

with the Maryland

death

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or itema 23a or 28e-f show other traumatic event, the Modical Example or most be notified at

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of ceptifier yaraxanir MD alle

C. VERGARA-SOARES

29c. License number D16619

29d. Date signed (Month, Day, Year) DEC. 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9940 FRANKIN SCHARE DR. WHITE MARSH, MD. 21236

State Registrar 31. Date filed (Month, Day, Year)
DEC 1 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death VERE Day Month Year Physician TT RICHARD MCINTYRE 11.55 PM 008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner eward en P word 0 507 8 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. Dec 1 M 2 F NC 84 Director 217-26-7507 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ire Pedical Examiner must be recilied at 1 □Yes 2 No **Ellicott City** Director MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21042 11326 Frederick Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates: Specify <u>Ş</u> Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) iled within College (1-4or 5+) Elementary/Secondary (0-12) Salesman Retail d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar 13387 Pipes Lane Sykesville, MD 21784 stepdaughter Shirley Mello permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 Removal from State Ellicott City, Maryland Dec 18, 2008 4 □ Donation 5 □ Other (Specify) Good Shepherd Cemetery 21. Si nature of Furieral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Noter the disease or complications that caused the death. Do not shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death nter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician ria disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bue to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 21/ No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy certificate | death? 2 2 🗆 No 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this Certification: To 1 Nnpatient After th funeral 28a. Date of Injury (Month, Day, 27. Manner of Doath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) the 29b. Signature and title of certifier 10 TO 29c. License number 29d. Date signed (Month, Day, Year) 22 00

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHE

31. Date filed (Month, Day, Year)

RYEE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** )onnie Mercer 39 AM /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3ALTIMORE BAYVIEW MEDICAL GOTER JOHNS HOPKINS Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 238-50-5872 73 Director Apr 19, 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDBaltimore 1 ☐ Yes 2√ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Eastern Blvd 21221 USA Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Decedor Armed Forces? 1 □Yes 2 □ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No Specify: \$ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Hopkins Bayview Medical Center</u> 4940 Eastern Avenue Baltimore, MD 21224

of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Signature of Euri Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate e (Final disease or condition resulting in death) respiratory Due to (or s a consequence of) Urosepsis Sequentially list conditions Examine day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24h Wara autonov findings available 24a Mac an 25 Be Certification: To 27

P.O. Box 68760 Division of Vital Records,

**Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and physician the as attending use the þ signed t page 2 should certificate this After thi ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu within 2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It... In a first in the righth of any injury or other traumatic event, It... In a first in right of any injury or other traumatic event, It...

**Physician** /Medical

Baltimore, Maryland 21215-0036

-					autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
25. Was case refer examiner?	red to medical									
1 ☐ Yes 2 💆	No	Hospital: 1 Inpatient 2	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, factorify)	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,				
29a. Certifier (Check only one)	1  Certifying Ph 2  Medical Exan	nysician: To the best of my kno niner: On the basis of examination	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)				

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year)

4940 EASTERN JOYCE KOH, M.D BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Restrar's Signature

State Registrar

Medical

29b. Signature and title of certifier

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 19, 2008 Hildegard Louise Mensch December 12:45 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rossville If Under 1 Year | If Under 24 Hrs. Franklin Woods Nursing Center Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 💢 F 78 8/31/1930 216-66-3969 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 George Avenue S. Α. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl A. Idler Frida Kettemann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Noell (Daughter) 1311 Gingerbread Lane Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gardens 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRA disease or condition resulting in death) dous Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a someoguerice off Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year □Yes 2 No 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

1 ∐ Yes 2X No

27. Manner of Death

1 X Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 ☐ Homicide

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

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2 should be filed within 72 hours after death with the Maryla and Mental Hygiene. Its marked other than "natural", or items 23a or 28a-f show raumatic event, it is Marked to the word.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event

Baltimore, Maryland 21215-0036

/Medical

burial-transit and attending physician for use as the buria signed by the a has

The law requires that the death certificate be executed

Hospital or Attending Physician:

the

Box 68760

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of Vital Records,

Division

certificate r this certifica : After thi death. within 24 hours after death

To the Funeral Director:
completely filled in by the

9 Unknown

25. Was case eferred to medical examiner?

Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XIII 2 No 1 ☐ Yes

red to medical 26. Place of Death (Check only one)								
No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 X Nursing H	dome 5 ☐ Residence 6 ☐ Other (Specify)				
n 5 □ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
6 Could not be determined		ome, farm, street, fac fy)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
1 Certifying Ph 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina	owledge, death occur ation and/or investiga	rred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)				

Une)	and manner stated.
29b. Signature and title of certifier	

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YIN OWNG

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 9

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2008 ecember Gerardo J. Mazzola 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ranklin Square Se da If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 □ F Days Hours 89 03/14/1919 Massachusetts 025-03-5307 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Fork 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12526 Harford Road 21051 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 Painter G. J. Schmidt Paint Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucia Iota Joseph Mazzola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Tina M. Patton</u> 12300 Sample Lane - Fork, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Air Memorial Gdns: 12/19/2008 | Bel Air, Maryland 21. agritus of Fune/al Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 le. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2/14/08 UNKnown 1 ☐Yes 2 No investigation tall

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

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ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at

is marked other

Department of Health a Important: If item 27 is any injury or other tra once.

Pages 1 and 2 should be nent of Health and Mental

Baltimore,

Physician: The law requires that the death certificate be executed and

attending physician for use as the buria the detached á signed be det director, page 2 should has certificate this After

Division of Vital Records, P.O. Box 68760,

or Attending

Hospital

the funeral after death filled in by

Examiner Physician/Medical ğ Completed Be

within 24 hours a To the Funeral D completely State Registrar

1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier cal

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation in my policing death account. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler

28e. Plate of Inj. ry - At home, farm, street, factory, office building, etc. (Specify) Home

N

bossible Syncol 28f. Location Street and Number o vural Route Number, City or Town, State) 12526 Hartord Road Fork

29c. License number 29d. Date signed (Month, Day, Year)

16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 F

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day H Year **Physician** , 2008 William G. McGuigan December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Washington Medical Center m Burnie Anna Ar If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 83 218 14 2995 **Director** Maryland <u>03/27/1925</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Director 1 ☐ Yes 2 X No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with U.S.A. 1151 Valley Drive 21122 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, Its Wellcal Event and injury or other traumatic event, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 [X]Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify ò Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician IBEW - Union 24 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas J. McGuigan Cathryn Pfaff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg McGuigan / 1151 Valley Drive Pasadena, Maryland 21122 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2008 Cross Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Partá. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUSUN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, æ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown director, page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has autopsy perforn certificate Vital 1 □Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? **Hospital or Attending** Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of 29c. License number 0 29d. Date signed (Month, Day, Year) 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUM 30 KOF

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death DECEMBER Day 6, 2008 **Physician** 4:12P Claire Marie McCormick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Saint Joseph Medical Center Towson 8. Date of Birth (Month, Day, May 22, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min <sup>Year)</sup> 1925 1 □ M 2 🗓 F 83 207-40-2049 PennsTyvania Usual Residence of Decedent 10a. State 10h Count 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore Stevenson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1531 Greenspring Valley Road 21153 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Tes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 □Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Joseph McCormick ပို Anna Devine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy McCormick / Sister 305 Cable Street, Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sisters of Notre
Dame Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 12-20-2008 Ilchester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral 21. Signature of Funeral Service License 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA DAYS disease or condition resulting in death) Due to (or as a consequence of): CARCINOMA OF THE BREAST 1 YEAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami ATRIAL FIBRILLATION YEARS Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria cate has been signed by the page 2 should be detached certificate director. this funeral After death.

after death filled in by 24 hours a Funeral L

Director

28a-f show

or items 23a

"natural"

alth and Mental Hygiene.

27 Is marked other than 'r traumatic event, the Menter than 'the 
Health a

permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once.

**Physician** 

/Medical

Examiner

the Medical

Examiner must be notified

the Marylan

death with ō

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

the within To the 3

2

Medical

State Registrar

DHMH 17 Rev 1/2001

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d, Date signed (Month, Dav. Year)

29b. Signature and title of certifie 52

D 25886

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON MARYLAND ILIA CEBALLOS M. D.

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)



DHMH 17 Rev 1/2001

State Registrar

DECEMBER 18,

JOANNE MCCARTHY

Mail as

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** AM BROWNIE ORNBORFF 2008 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard **Howard County General Hospital** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 F Months Hours Yrs MD 180-07-0915 94 Director Aug 26, 1914 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show traumatic event, the Medical Examiner must be notified at Director Scaggsville 1 ☐ Yes 2 No MD Howard 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ò 20723 10909 Scaggsville Rd. U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 ö Specify: Specify: à White 3 Widowed 4 Divorced 'natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. than Elementary/\$econdary (0-12) College (1-4or 5+) Homemaker **Own Home** 12 should be filed wi h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked i any injury or other traumatic ev John L. Hines Margaret S. Leishear ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12701 Clarksville Pike Clarksville, MD 21029 June Pickett Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 18, 2008 4 Donation 5 Dother (Specify) Fulton, MD St. Paul's Lutheran Cemetery re of Funeral Service Licensee 22. Name and Address of Facility Munkallar Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician MYOCARDIAL INFARCTION -2 HRS dease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ISCHEMIC HEART DISTAGE rulliple years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner y and law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. icate has been si , page 2 should b ATLACE FIBRILLATION, CONSISTING MEAST FRICKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an MORTH ANEURYDA autopsy performed? 1 □ Yes 2 💆 No certificate Division of Vital Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA မှ this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the pletely filled in by the funeral 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? 5 Pending investigation Injury Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29b. Signature and litle of certifie 29c. License number 29d. Date signed (Month, Day, Year) MOG6481 866 12 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Bactimore MD 21287 GOW Nouth walle MATTHEW J. CFUY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State blen burnie 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn GREENE FUNERAL 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart tallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PREUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. sician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) □Yes P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. 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Registrar

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Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. amend item330perDVR, 6886, 12/19/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 15, Roling Parker December 6:47 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Hospice Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/08/1955 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F 217-64-8327 53 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State or 28a-f show notified at 1 □Yes 2KNo Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 must be n 1204 Pine Crest Court 20657 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗷 No Specify: Black Specify: ò 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) other than ' Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Artesian Weld Drilling Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore R. Parker Ellen Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 Is any injury or other trat once. Irene Parker/Wife 1204 Pine Crest Ct., Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 12/18/2008 Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive, Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 disease or condition resulting in death) /Medical Due to lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Da and Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 12 00

DHMH 17 Rev 1/2001

State Registrar Manoj

Mathur

31. Date filed (Month, Day, Year)
DEC 1 9

Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year December 15, 2008 Anne Pecora 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Baltimire maryland General If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Days Hours 62 217-52-1957 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Baltimore 1 XYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 211 Bolton Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor of Law Attornev 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert William Kluge Jean Mae Rasmussen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Pecora/Husband 211 Bolton Place, Baltimore, MD, 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 12/17/08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit CAFA/Stephen D Lohrmann P.A. 21. Signature of Funeral Service Licensee Green Pastures Dr, Towson, MD, 21286 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner P.O. Box 68760, Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed and physician nse for L has certificate this filled in by the funeral 24 hours after death. Funeral Director: After completely To the within 2

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendlar Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified at

Pages 1 and 2 should be in nent of Health and Mental

**Physician** /Medical

/Medical

MD

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed

Be

Medical Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

DEC 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32.

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Augustus S. Pickens Jr EMBURLL 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1 ☑ M 2 □ F 247-22-3353 85 May 21, 1923 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 700 W. 40th Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian 1XiYes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) employment manager B&O railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus P. Pickens Myrtie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Good Samaritan Hospital 5601 Loch Rquen Blvd Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part1 Enter the disea of, or of inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASTIRATION YIFKTER DA Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequency of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

**Physician** /Medical Examiner Examine law requires that the death certificate be execu

**Physician** 

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, It's Medical Exeminer must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important; If item 27 is marked other

Baltimore, Maryland 21215-0036

3

PIRICEN

Box 68760,

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Division of Vital Records,

Hospital or Attending Physician:

/Medical

attending physician and for use as the burial-trar Physician/Medical signed by the a page 2

within 24 hours after death

To the Funeral Director:
completely filled in by the

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Completed

Be

Certification: To

Medical

								24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case refer	red to medical					26. Place of De	eath (C	heck only one)	
examiner? ◆ Yes 2 □	No	Hospit	al: 1 ☐ Inpatient 2☐	EB/Outpatient	3 🗆	DOA Other: 4 Nursing I	Home	5 ☐ Residence 6	Other (Specify)
27. Manner of Death  1	5 Pending investigation		a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □Yes 2 □ No	28d	. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28	e. Place of Injury - At h building, etc. <i>(Spe</i> c	nome, farm, stree	t, facto	ory, office	28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only	Gertifying Ph 2 Medical Exar	ysicia niner:	n: To the best of my kn On the basis of examin	nowledge, death of	occurr	ed at the time, date and place on, in my opinion, death occ	ce, and	due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

0018230

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		artment of F rtificate of I			giene Reg. No. 2000	0 40720
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Thelma Marie F	Peddi pord				2. Date of Dea Month	16 200E	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s			4b. City, Town, or	r Location of Deat	December	4c. County of De	
	Examin	er	Gilchrist Center		are	Towson			Baltin	nore
ı	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day September	9. B r 9, 1929 M	irthplace (State or Foreign Country) aryland
	nu w		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	cation				10d. Inside City Limits
45	Maryla -f sho ied at	ţo	MD Queen Ai		ester					1 □Yes 2 🛣 No
#	vith the I	Funeral Director	10e. Street and Number			10f. Zip Code <b>21620</b>			10g. Citizen of What C	
4	eath v ns 23a must	eral	101 Hoffman Lane	12. Was Decedent Ever in U.S	3. 13. \		lispanic Origin? (S	pecify Yes or No-		
326	be filed within 72 hours after death with the Maryland that Ugene. d other than "natural", or items 23a or 28a-f show event, the "heart at Eveniner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1		lfYes, specifyCuba 1□Yes 2XINo	an, Mexican, Pueri Specify:	o Rican, etc.)	Black, Wh	ite, etc. Lhite
5-0036	72 hou nature lical E	Completed	15. Decedent's Educ (Specify only highest grade	cation		dent's Usual Occup		kina i	16b. Kind of Busines	s/Industry
121	within sne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	nt Repres	d) -		Telephone	
N.	Hvg Hvg ent, I	Be Co	17. Father's Name (First, Middle, Last)			,			Maiden Surname)	
yland	7 × 2 ×	To B	Henry Peddicord				Margar	et Unkno	 JM⊔	
Mar	2 <del>2</del> E		19a. Informant's Name/Relationship (Type: C. Brian Donhause:		1	•			er, City or Town, State um, Marylar	
	s 1 and f Health item 27 other t		20a. Method of Disposition	20h P	lace of Dispo	sition (Name of	1	Date	20c. Location - City of	
2	Pages ment of an:If it un or o	9 3	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Dull	aney V orial	natory or other place alley Gardens	12/2	20/2008	Timonium,	Maryland
Baltimore,	permit. Pege Department of Importan : If any injun. or once.		21. Signature Funeral Service Licens	Fully )		2. Name and Addre	- 1	Ruck Tows wson, Ma	on Funeral aryland 21	Home, Inc. 1204
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
1.	Physician		Immediate Cause (Final disease or condition resulting in death)	STROKE						WEEKS
	/Medical Examiner			Due to (or as a consequ		LATION				115405
	D ( ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ						JEM 3
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	rence of):					
8/60	te be e ysician e buria	dical E		ı						
89 9	ertifica ling ph e as th	Medi	IF FEMALE:							
). Box	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	c. If yes, outcome of pregnancy  1					elivery Day Year
1	that the ed by the detached		9 ☐ Unknown  Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds,	requires that been signed to hould be deta	ed by	DIABETES					1 □ Y	′es 2 No 3 □	Probably 4 🔀 Unknown
Records,	8 9 0	Completed						24a. Was a	sy prior to	autopsy findings available completion of cause of
_	sician: The la certificate ha rector, page 3							1 □ Yes	•	? es 2 □ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔼 No	lospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier	nt 3 🗆 DOA Oth	or:	ath (Check only of	ne) lence 6 <b>⊠</b> Other (St	pecify) HOSICE
n o	Attending Physician: It death. ector: After this certific. by the funeral director, I	on:T	27. Manner of Death 1 M Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o		ry at		now injury occurred	icony) / real real
Division	ttendii Jeath. Itor: A the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me form etr		Yes 2 □ No	28f Location /6	Street and Number or	Dural Pauta Numbar
<u>≥</u>	al or Atten safter deatl I Director: d in by the	Certification: To	4 ☐ Homicide determined	building, etc. (Specify	y)	eet, factory, office		City or Tow	n, State)	Turar House Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo.	
			1	11/1 ~	-	Da	4395		December	216,2008
	K		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)	S ST, SU.	17 209	BALTIMOR	E,MO 21204
F	Sta	te	30. Name and address of person who con the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	32 Registrar's Signa	ture (					
	Registr	ar			-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b-f.perINF.G886.12/24/08.WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** M Nancy J. Romaniello December 12. 4:50 P 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 □ M 2 □ F 215-42-5570 Nov. 21, Maryland Director 1943 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location **Baltimore**Parkville 10b. County 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examinar must be notified at 1X Yes 217 No Funeral Director Maryland -Paltimom 10g. Citizen of What Country? et and Number
W. 36th Street 10f. Zip Code 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**X** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Knopp Helen N. Baker ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Tryhubenko - Daughter 2405 Hilford Dr. Parkville, MD 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/18/2008 Parkville, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licenses 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscleratic Immediate Cause (Final **Physician** andiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Po Month Year 5 Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform eral Director; After this certificate filled in by the funeral director, pag 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number December 16,2008 completed cause of death (Item 23a) (Type, Print) 4:11 CT. Lutherville, Md 21093 18 6

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

9

2008

32. Registrar's Signature

			1 1000	State of Ma	ryland /	Depa	rtment of H	lealth a	nd Me	ental Hygie	ene	1010.	
			For State Registrar	Otato of Ivia	arylaria /	-	tificate of l		110 1110		. No. 2	108	40730
-	*		Decedent's Name (First, Middle, L.)	ast)					2	2. Date of Death			3. Time of Death
	Physicia		Norman R	le quiters					1	Month November	20 <b>.</b>	Year 2008	8:00 AM <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, g	-			4b. City, Town, or	Location of		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		y of Death	10.00
4			Genesis Long Gr	een Center				imore					
	Funeral		,	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last		If Under 1 Year Months Days	If Under 2	Min.	B. Date of Birth (Month, Day, ) Iov 3, 1	(ear)	9. Birthp Coun	lace (State or Foreign htry) unk
	Director		217-26-0475	IA W ZUI	79	Yrs.			N	lov 3, 1	929		
	and	}	Usual Residence of Decedent  10a, State 10b. County		10c. City, To	own or Loc	cation					1	0d. Inside City Limits
	f sho	0	MD			Ro1	timore						1 Yes 2 No
	the 1	Director	10e. Street and Number			Dal	10f. Zip Code	<u> </u>	_	100	j. Citizen of	What Cour	ntry?
	3a or		115 E. Melrose	Avenue			21:	212			USA	1	
	death ms 2	Funeral	11. Marital Status unk	12. Was Decedent E Armed Forces?	er in U.S.11	nk 13. y	Vas Decedent of H	ispanic Origi	in? (Spec	ify Yes or No-		ice - Americ	
٥	after or ite mine		1 ☐ Never Married 2 ☐ Married				☐ Yes 2 No	Specify:	, i deno ii	iouri, cio.	Speci	b1	ack
OC 20	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						unk 1			unk
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7	within 72 ene. than "na he Medic	ᇍ	Elementary/Secondary (0-12) unk	College (1-4or 5- unk	+)			,					
D	filed Hygi Sther ent, t	a)	17. Father's Name (First, Middle, Las	st)			unk	18. Mother	r's Name (	First, Middle, Ma	aiden Surna	me)	unk
au	Aental Aental rked o	To B											
ar	2 shou and N Is mai		19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailin	g Address (Street	and Number	r or Rural	Route Number, (	City or Towr	n, State, Zip	Code)
Ξ.	and 2 ealth n 27 I		Genesis Long Gre	en Center			E. Melros	se Ave			e, MD	212	12
more,	Jes 1 of He if iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place ceme	of Dispos etery, cren	sition (Name of natory or other plac	e)	Da	te 20	c. Location	- City or To	own, State
Ē	Pages tment of tant: If its jury or o		4 □ Donation 5 ₺ Other (Spec	cify) in state	e								
	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Lo Ronald	enwade Dire	etor		Name and Addre				balti	imroe	Street
	402 40	-	23a. Part1. Enter the disease, or co	applications that caused	the death D		altimore		2120		t	-	Approximate
			shock, wheart failure. List on Immediate Ca. (Final	proplications that caused ly one cause on each lin	ne.		1 ===	f	ar diao or	. ^	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to or as a	a consequence		ingronasc	ulor e	SUNE	032			
	Examiner			Chion	ic ol	ostvu	chare no	ilmia	Olen 1	Luass	)		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequenc	ce of):	1		1				
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Advo	nced	de	mente	عر					1
/60,	ate be executed nysician and he burial-transit		resulting in death) cast	Due to (or as a		,	0 (						
2	physic the t	dical		d. Lur	19 0	ance				-			
	death certificat attending phy I for use as the	/Me	IF FEMALE:	23c. If yes, outcome	pf pregnancy						23d D	ate of delive	erv
ROX	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)	/				lonth	Day Year
5	t the by the	Physician/Med	9 Unknown	9□Unknown									
в.	w requires that the death certificate been signed by the attending physi should be detached for use as the	by P	Part II. Other significant conditions	contributing to death bu	ut not resultin	g in the ur	nderlying cause giv	en in Part I.					he cause of death?
Kecords	equir sen si ould	ted								1 ☐ Yes	2 No	3 □ Prob	oably 4 Unknown
Ö		Completed								24a. Was an autopsy		prior to co	psy findings available mpletion of cause of
_			/							perform 1 Yes 2	No No	death? 1 ☐ Yes	2□No
VITal	sician certifi rector	Be	25. Was case referre o medical examiner?	Hospital:			, act pos Oth	or: /		(Check only one			
ō	Phys r this ral dii	- T	1 ☐ Yes 2 ☐ No  27. Many r of Death	1 ☐ Inpatie		Outpatien b. Time of	I 3 DOA	4 🖭 Nur		e 5 Residen			(y)
o	nding th. : Afte e fune	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day	y Year)	Injury	h	ƙ? Yes 2∐1\	No				
IVISION	Atter	ifica	3 ☐ Suicide 6 ☐ Could not determine		ury - At home	, farm, str	eet, factory, office		28	3f. Location (Stre		nber or Rura	al Route Number,
Ē	tal or safte al Dir	Certification:											N. C. C. C. C. C. C. C. C. C. C. C. C. C.
<b>)</b>	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,		(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of	f examination	dge, death and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, a th occurre	nd due to the cau d at the time, da	use(s) and n te and place	manner as s e, and due t	stated. o the cause(s)
	thin 2 the 2 the 1	Medical	one) 29b. Signature and tale of certifier	and manner sta	ated.		29c. Licens	e number		29	d. Date sign	ed, (Month,	Dav. Year)
	7. <u>₹</u> ₹ 8	_	OLKK	/ 1110 .				0647	88		17 / 9	10 V	, , , , , ,
			30. Name and address of person wh	no completed cause of de	eath (Item 23	a) (Type		5041	3 0		14	100	
			VIJAT S	MARMA , A	10	1600	W. MT.	ROYA	LAUT	BAU	MORF.	MD 2	1217
	Sta		31. Date filed (Month, Day, Year)	Se. Registra	ar's Signature	Also.	R.J						
	Registi	ar	DEC 1 9 20	JUU JUNE	100	1	-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of Ivial	Cei	rtificate of			eg. No.	08	40731
Г	Physici	an	1. Decedent's Name (First, Middle					2. Date of Deat Month		Year	3. Time of Death
**	/Medic	cal	Edgar A. Reeve			4h City Tours o	r Location of Death	December			9:35 PM M
Ĵ.	Examir	er	Anne Arundel M		r	Annapol			4c. County Anne		la1
	Funeral				(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		
	Director		520-18-6058	1 <b>∑</b> M 2□F	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov 26,	1924	Cour Co1	olace (State or Foreign orado
	pu »		Usual Residence of Decedent  10a. State 10b. County	1.	40- Oit T			·			04 1-14-04 11-3
	f shore	ō		Arundel	10c. City, Town or Lo					'	0d. Inside City Limits 1 ☐ Yes 2√☐ No
	28a-1	Director	10e. Street and Number	Tunder	Annap	10f. Zip Code		11	0g. Citizen of \	Mhat Coun	21
1	should be lied within 72 hours after death with the Maryland Ad Mental Hygiene. marked other than "natural" or items 23a or 28a-f show matic event, the Medical Ever, front institute notified a	Ē	930 Astern Way	\$412			21401	"		JSA	
	death	Funeral	11. Marital Status	12. Was Decedent Ev	rer in U.S. 13.	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		e - Americ	
9	or Ite		1 ☐ Never Married 2 🔀 Marrie	Armed Forces?  1 ☑Yes 2 ☐ No If Yes, Give	, .	l⊡Yes 21XINo	Specify:	nican, etc.)		ck, White, e	
	uural",	d by	3 Widowed 4 Divorced	Year or Dates:	<b>'</b> 43 <b>–</b> 46					whi	
5	in 72 n"nal Malici	Completed	15. Decedent's (Specify only highest	t grade completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of work	ring	16b. Kind of B	usiness/Ind	iustry
212	r thai	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			ram leade	r	educ	ation	L
פ	e nied wi al Hygier other th vent, th	BeC	17. Father's Name (First, Middle, L	•			18. Mother's Nam				
<u> </u>	snould be I and Mental s marked o	2	Edgar Allen Ree	ves Sr			Florenc	e Luciel	Blair		
ַ שַ	S 8 55		19a. Informant's Name/Relationsh Marjorie Reeve		19b. Mailin 930 <i>A</i>	g Address <i>(Street</i> Lstern Wa	and Number or Rui y #412 An	ral Route Number, inapolis.	City or Town,	State, Zip 1401	Code)
. ن	of Health of Health item 27 i		20a. Method of Disposition		20b. Place of Dispos	sition (Name of	1 1		20c. Location -	City or To	wn, State
٤	rages nent of int; If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 🕅 Donation 5 ☐ Other (So	3 ☐ Removal from State ecify)	cemetery, cren	natory`or other plac	ce) ;				
Baitimore,	permit. Pages Department of Important; If it any injury or conce.		21. Signature of Funeral Service		ctor St		ss of Facility Omy Board		Baltim	ore S	treet
			23a. Part . Enter the disease, or d	complications that caused th	ne death. Do not ente	<b>1timore</b> , er the mode of dyin	MD 2120 ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
, P	hysician	i	Immediate Cause (Final	nly one cause on each line.	Aarte M						Onset and Death
7	/Medical		disease or condition resulting in death)		consequence of):	To consu.	uc 4miles	CHON			days
E	xaminer		Sequentially list conditions	b							
70	sit a	Examiner	Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a s	ButiBeduchBu of);					21	
ox 68760,	incate be executed  ng physician and  as the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a c	consequence of):						
6876U,	siciar buria			` `	, , , ,						
20	in phy as the	Medical		u.							
X or	attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnanc			23d. Da	te of delive	ry
, e	the at	sici	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at til		Other (specify)	у		Mo	nth	Day Year
The law requires that the death	h. After this certificate has been signed by the funeral director, page 2 should be detached	Physician/	9 ☐ Unknown  Part II. Other significant condition		mak namulkima in khan sa	alaahdaa aassaa abs	an in Daniel	Ogo Did tob		-:	a server of death?
ecords,	signe d be c	by	s are in Other significant condition	is contributing to death but i	not resulting in the un	denying cause givi	en in Fan I.				e cause of death?
	peen	Completed									
	e has	E I						24a. Was an autopsy perform	/	Were autor prior to cor death?	osy findings available npletion of cause of
VITAL	ifficate or, pa		25. Was case referred to medical					1 □ Yes 2	No	1 □ Yes	2 □ No
> 100	s cert	o Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	2 ER/Outpatien	Othe	26. Place of Deatler:	n <i>(Check only one</i> me 5 ☐ Resider	·	(O · · · · '	
5 8	ter thi	i i	27. Manner of Death	28a. Date of Injury (Month, Day, Y		28c. Injury		28d. Describe how			<i>"</i>
SION	oath.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	ition	injury		Yes 2 □ No				
	after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Numb State)	er or Rura	Route Number,
Hoenita	within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, p.		(Check only 2 Medical E	Physician: To the best of r xaminer: On the basis of ex	xamination and/or inv	occurred at the tir	me, date and place, pinion, death occur	and due to the ca	use(s) and ma	anner as st	ated. the cause(s)
of t	ithin 2 o the omple	Medical	20h Signature and title of configur	and manner state	a.	200 Liconor	a number		Net Detection		
۲	· s ⊨ ō		30. Name and address of person w	real Bech, H	<i>10</i>	1	46052	,	12/	11/08	
			30. Name and address of person w	ho completed cause of deal	th (Item 23a) (Type F	rimparhway	, annapa	es Mo			

State Registrar 31. Date filed (Month, Day, Year)
DEC 1 9 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician John Ambrose December 12:09AM Rucker 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 26, 1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 12 M 2□F 217-26-3467 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weden Examiner must be notified at once. 1 ☐Yes 2 NO Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 Belvedere Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: ģ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Super Market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Rucker Adaline Fox ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Veronica T. Rucker/Wife 107 Belvedere Avenue Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Mem. 2008 Crownsville, MD 22. Name end Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services/1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Errent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** e. Chomic Obstruction Polomay Desine with To brosic yeare disease or condition resulting in deeth) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriarl transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Acterioscleshi Coronay Orcelan Dig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed colules 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1No 1 ∐Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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7-17-2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Muchael

31. Date filed (Month, Day, Year)

ic currel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 Year 2005 Melvin C. Ruddle ecember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death B Glen Baltimore Washington Medical Center かんしょる If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Months Days Hours Min. 234-46-7080 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Maryland Severn Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8434 New Cut Road 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 14. Race - American Indian. 1 ⊋Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechānic Air Craft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Ruddle Floda Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8434 New Cut Road, Severn, MD 21144 Frances M. Ruddle (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that saveed the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequire ce of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

attending physician and for use as the burial-transi

been signed by the should be detached

After this certificate has funeral director, page 2 s

ours after death.
neral Director: Af
filled in by the fur

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Certification: To

Medical

The law requires that the death certificate be executed

or Attending Physician:

Hospital within 24 hours a

P.O. Box 68760.

of Vital Records,

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**Physician** 

/Medical

Examiner

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt. If item 27 is marked other than "natural", or items 22a or 28a-f show unty or other traumatic event, Item Marical Exp. Inset Po. Auffind 21

Baltimore, Maryland 21215-0036

Examiner

Examine Physician/Medical Completed by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

24a. Was an autopsy perforn 2 No 1 □ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 **X**No

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Appatient 27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

MY

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print OWUSU -IN 100 JE

31. Date filed (Month, Day, Year)

gistrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Charles Clay Smith DEC. 2008 9:40 n /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott Ci 3010 N. Ridge Road Apt. 706 City Howard 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min. 1 XM 2 □ F Months 92 Director 088-05-4228 Jan 22. 1916 NJ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Addreal Examinar must be notified at 1 ☐Yes 2 ☐No Director Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the "defeal Examine mast bar. ury or other traumatic event, the "defeal Examine mast bar. 3010 N. Ridge Road #706 21043 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White þ 3 ₩idowed 4 Divorced WWII Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Treasurer Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Nelson Smith Dorothea Koch ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph T. Smith (Son) 5910 Snowdens Run Rd., Sykesville, MD 21784.

Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12/22/08 Sykesville, MD 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL LUNG **Physician** SMALL NON YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy certificate 2 No 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Assisted Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Records, Division of Vital Hospital or Attending Physician: n 24 hours after death.

The Funeral Director; After pletely filled in by the fur To the Fune completely fi To the within 24

(Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE MD 21229 AGNES COLE 900 ST

State Registrar 31. Date filed (Month, Day, Year) DEC 1 9 2008

29a. Certifier

Brian Corlos Smith 08-09286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK	1	State of Maryland / Departmen - For State Certificate			Mental H		200	08 4073				
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)			H Lee	-2. Date of Dea		3. Time of Death				
Medical Examin	er	Brian Carlos Smith				Decembe	r 10, 2008	2108 hrs				
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Furnanel		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		Inder 1 Year	If Under 24Hrs	8. Date of Bi	rth(MM/DD/YYYY) 9. Bi	rthplace (State or				
Funeral Director		216-84-4466 12M 2DF 37	<i>"</i>	onths Days	Hours Min	-	22 197/ C	ountry) Mary and				
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' any	- 1	10a. State 10b. County 10c. City, Town or L	1									
iand f show	ō	Maryland N/A Balti					1 Yes 2 No  Og. Citizen of What Country?					
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f.	Zip Code	12		(In Heal)					
ith the		3704 Elmely Avenue  11: Marital Status  12. Was Decedent Ever in U.S. 13	3 Was Dec	-	panic Origin? ( S	pecify Yes or N		14. Race - American Indian, Black,				
eath with the tree sale sale tree sale items 23a	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, sp	ecify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc.					
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215 be filed ital Hy ked ol	Be	George Smith			Veroni	ca 7	ownsend					
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marice event, the Medical Examiner must be notified at once	2	Total Intelligence of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of	Nailing Add	ress (Street	and Number or		ımber, City or Town, Sta					
- p-# = 8		Dovica Ballard Smith - Wife 37 20a. Method of Disposition 20b. Place of D	164 E	Name of cert	netery HUR,	Balt Date	20c. Location - City	or Town, State				
Baltimore, MD 21215-0036  bermit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.  important: If item 27 is marked other than "naturial", njury or other traumatic event, the Medical Examiner.			emitter pl	ace)	.,.	23	Hanoyer	· Mo				
트 집 후 트 니		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		and Address	/ / / /	11- 1408	therford E					
Balti permit: Departm Importa	ļ	a win L. Martin	3 5		W E / 01			WD =(LL)				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mo					Approximate Interval Between Onset and				
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Kaiiiiiei		or condition resulting in death)  Due to (or as a consequence of):										
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		1		1						
$\rightarrow$	Examiner	Cause. Enter Underlying Cause (Disease or injury that Initiated  C.										
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cords, law requir has been s	plet					aut	opsy prior to	o completion of cause of				
Rec The le	Som	24a. Was an autopsy findings prior to completion of death?  1 ✓ Yes 2 No 1 ✓ Yes 2										
tal Rec	Be (	25. Was case referred to medical examiner? Hospital:		26.Place DOA	of Death (Chec	k only one) sing Home 5	Residence 6 Ott	ner:				
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on on on on on on on on on on one on one one	ion:	1 Natural 5 Pending Dec 10, 2008 2026 h		1	Yes 2 ✓ No	Subject sh	not					
Division ral or Attendi ral Director: /	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, fa	ctory, office b	ouilding, etc.			Rural Route Number, City				
Div	Certification:	4 Momicide determined (Specify) Outside				3000 block	, State) Pulaski Highway, Bal	timore, MD				
Division of Vital Records, P.O. Box 6876 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the burneral by the funeral director, page 2 should be detached for use as the burneral director.		29a. Certifier (Check only one)  Q Medical Examiner: On the basis of examination and/or inv	occurred a	at the time, da	ate and place, ar	nd due to the ca	use(s) and manner as site and place, and due to	lated. the cause(s)				
To th within To th	Medical	2 www.and manner stated.  29b. Signature and title of certifier		29c. Licens			29d. Date signed (#					
	_	Patin Dann		O.C.			December 11,					
,		30. Name and address of person who completed cause of death (Item 23a)										
$\emptyset$		Patricia Aronica-Pollak MD. Assistant Medical Examir	ner 11	1 Penn St	treet, Baltim	ore, MD 212	201					
	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	A	0				-				
Regist	ffelf	DFC 1 9 2008   Charles   A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#19a&20b perFH 9886 12/19/08 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 08: 30 A M Larry Smith DECEMBER 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ₩ M 2 □ F Director 218-14-7416 85 1-1-1923 VA Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be netified at 1 XYes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 1117 Darley Avenue 21218 S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Black 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emmitt Smith ပ Cornelia Foster 19a. Informant's Name/Relationship (Type. Print)

Jettie Fedellia Smith-Wife

Jettie Mith-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 1117 Darley Avenue Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 21-08 Balto, MD Trinity Cemetery 12-22 Name and Address of Facility 21. Signature of Funeral Service Licenses March East F/H la W 1101 E. North Avenue Balto, and MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Weeks PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 Neeks PLEURAL EFFUSION Sequentially list conditions Examiner Due to or as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed YEAR HEART FAILURE CONGESTIVE and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician 1 YEAR ANEMIA Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an has autopsy performed Yes 2 certificate 1 ☐Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after deatl filled in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical **completely** (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ASHA SASIMANGALAM, MD AT 2438946 DECEMBER - 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ASHA SASIMANGALAH ,201 E-UNIVERSITY PKWY, UNION MEMORIAL HOSPITAL, BALTIMORE, MD 21218

08-09435 Stanislaus Shirley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifica Registrar	ate of Death	Reg. No.					
Physici ical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year December 15, 2008	3. Time of Death 1715 hrs				
		4a. Facility Name (if not institution, give street and number)     4105 Century Road	4b. City, Town, or Location of Death Baltimore	4c. County of D	eath				
Funeral Director		5. Social Security Number 217-50-1241 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) 9	Birthplace (State or preign MD Country)				
, u		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits				
Maryland 28a-f show any 1 at once.	ō	MD N/A BALT	TIMORE		1 X Yes 2 No				
death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	10e. Street and Number 4105 CENTURY RD	10f. Zip Code 21206	10g. Citizen of What (USA	Country?				
	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( Spilf Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, et	merican Indian, Black, c. HITE				
ours after	d by		1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of v	work done 16b. Kind of Busine					
5-0036 led within 72 he Hygiene. other than "n:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti TECHNICAL ENGINEE		YWELL				
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last)  MELVIN S. SHIRLEY		e (First, Middle, Maiden Surname) ARY T. LEASE					
10re, MD 21215-0036  gges 1 and 2 should be filed within 72 hours after in of Health and Mental Hygiene.  F. Iftem 27 is marked other than "natural", other traumatic event, the Medical Examiner.	To		o. Mailing Address (Street and Number or F 21370 NATIONAL PIK	Rural Route Number, City or Town, S XE NE FLINTSTONE	tate, Zip Code) , MD 21530				
Baltimore, Normit Pages Land Department of Healtlinportant: If item		1 Burial 2 X remation 3 Removal from State cremate	of Disposition (Name of cemetery, ory or other place)  NTIC CREMATORY	Date 20c. Location - Cit 12/20/08 GLEN E	y or Town, State				
Baltimo permit Page Department o Important: injury or oth		Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL H 6415 BELAIR RD BALTIMORE, MD 21206							
Physician /Medical		23a Part I. Enter the tisease, or complications that caused the death. Do not failure. List only one cause on each line.	of enter the mode of dying, such as cardiac of		Approximate Interval Between Onset and				
✓ Examiner		Immediate Cause (Final disease or condition resulting in death)  a Hypertensive Athersclerotic Due to (or as a consequence of):	Cardiovascular Disease		Death				
	-Le	Sequentially list conditions, if any, leading to immediate b							
/	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	T						
recuted and transit	al Ex	d.							
760, Trate be extra physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	Werv				
Division of Vital Records, P.O. Box 68760,  Mospital or Attending Physician: The law requires that the death certificate be executed to hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - transit.	sician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5			Day Year				
D.O. Be that the de ned by the detached fo	Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?				
S, P.O.	ed by	Asthma		1 Yes 2 No 3	, 152				
of Vital Records,  of Physician: The law require the this certificate has heen si neral director, page 2 should b	Completed	Obesity			e autopsy findings available to completion of cause of 1? Yes 2 No				
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner? Hospital: 4 locations 2 EB/O	26.Place of Death (Check		Nomened				
n of Vi	27 Manager of Pooth								
Division tal or Attendir as after death.  Al Director: A led in by the fu	atio	1 Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No						
Division ospital or Attend hours after death nerral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)  286. Place of Injury - At nome, ta (Specify)	ırm, street, factory, office building, etc.	28f. Location (Street and Number of or Town, State)	Rural Route Number, City				
To the Hos within 24 h To the Fur completely	edical	(Check only 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated							
E 2 E 8	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (					
10		30. Name and address of person who completed cause & death (Item 23a)	O.C.W.E. OCM	December 17	2000				
1		Theodore M. King, Jr., MD. Assistant Medical Exami	iner 111 Penn Street, Baltimore	e, MD 21201					
St Regist	ate	111 1 1 2 / 11110 1 // 7/8 1 / 1/8/	Boards 1						

State of Maryland / Department of Health and Mental Hygiene | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** William John Schmitt 1:27 P M December 16, 2008 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Ctr. Bel Air Harford Co If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months 213-26-1044 Director 79 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or Itams 23a or 28e-f show traumatic event, the Madical Examples 1 ast by netfind at 1 ☐ Yes 2 🖾 No Directo Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Fox Bow Drive 21014 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 28 No If Yes, Give Year or Dates: 1 Never Married 252 Married 1 ☐ Yes 2 No Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be lifed within 72 Department of Health and Mental Hygiene. Important: If licen 27 is marked other than "netuany injury or other traumatic eventual." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 Years College (1-4or 5+) Mechanic National Can Co 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph V. Schmitt Lillian Kaptain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy A. Schmitt (Wife) 615 Fox Bow Drive Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 12/19/2008 Middle River, MD 21. Signature of Emph Service Licens e 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Pert1, Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one caus on each line Immediate Cause (Final disease or condition resulting in death) esuiro Pnysician 100 /Medical Due to (or as a consequence Examiner ( Sagrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Due te Examiner のすのりか Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached P.0. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? res 24 No 1⊟ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? \_\_ Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending within 24 hours after death. To the Funerel Diractor: After 5 Pending investigation 2 Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 H0053869 and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Clesope de مرساس UCMC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER **Physician** J. Day 2/2/12/8 Doris Shumate 03:15PM /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Medical Towson Center 8. Date of Birth (Month, Day, Year)
Dec. 15,1924 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2🏞 F Days 230-24-6615 84 Kentucky Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show s 23a or 28a-f show Baltimore County Maryland Baltimore 1 Tyes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7239 Bridgewood Drive 21224 United States Funeral death items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ?7 is marked other than "natural", or items traumatic event, the Modeal Examination. 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ No Specify. þ Specify. White 3℃ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Manufacturing 12 Years permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Jackson Margaret Loftice ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7239 Bridgewood Drive Baltimore, Maryland 21224 Brenda S. Emche (Daughter) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 12/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 00 1 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 WEEK Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) / /Medical Due to (or as a consequence of) Examiner DEMENTIA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) P.O. s been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has page 2 s 1 ☐ Yes 2 1 ☐ Yes spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate ly filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Medical

(Check only one) 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UTZSCHMEIDER

Registrar

DHMH 17 Rev 1/2001

D

32. Registrar's Signature

29c. License number

D52096

ER.

DRIVE

29d. Date signed (Month, Day, Year,

21204

TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician**  $a^{M}$ Evangeline Sutton 2008 7:35/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1407 N. Decker

5. Social Security Number 6. Sex Avenue Baltimore N/AAge (In yrs. last birthday) 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. Director 223-32-4622 6-25-1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 XYes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1407 N. Decker Avenue 21213 U S Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc □Yes 2 Yes, Give 1 ☐ Never Married 2 ☑ Married 3( NO , or Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. <u></u> Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Housewife Home marked other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Richard Ford Lillian Harris ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Health Shade Sutton-Husband 1407 N.Decker Avenue Balto, MD 21213 Department of Health Important; If item 27 any injury or other troone. 27 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-08 MDNational Mem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H E. North Avenue Balto, MD w a 1101 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENID **Physician** disease or condition resulting in death) /Medical Lue to (or as a consequence of): **Examiner** RUSCIERUTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine burial-transit YPERTENSION Hospital or Attending Physlcian: The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl for use as t IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by YPERTENSION 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗷 No OUTY 2 No 1 Yes this certific 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Af eletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gert 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ALTIMORE, NID 21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Virginia T. Simering Dec 12, 2008 9:45 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Morningside House Ellicott City Howard Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 N F Months Days 215-18-7558 85 MD Feb 21, 1923 Usual Residence of Decedent 10b. County 10c. City, Town or Location

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

> burlal-transit completely filled in by the funeral hours after death. uneral Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760,

NO. CILIC	Harrand	100. Oily, 10111 of 2000	F11* 44 6			1 ☐ Yes 2 No		
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10e. Street and Nu			10f. Zip Code	10	g. Citizen of What Co	•		
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3 ☐ Widowed	If Yes Give	1	□Yes 2 No Specify:		Specify:	<b>/</b> Vhite		
· · · · · · · · · · · · · · · · · · ·	15. Decedent's Education		ent's Usual Occupation	. 1	6b. Kind of Business/	Industry		
(Spec	cify only highest grade completed) ondary (0-12) College (1-4or	life. Do	ind of work done during most of wo O NOT use retired)	rking				
12		Keo	u Estate		Rea	I Estate		
17. Father's Name	(First, Middle, Last)		18. Mother's Nat	me (First, Middle, M	a <i>iden Surn</i> a <i>me)</i>			
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	ame/Relationship (Type. Print)		Address (Street and Number or R.			Zip Code)		
Jeffrey \$	Simering - son		D Five Fingers Way Col		1045 0c. Location - City or	Town State		
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41.	5 ☐ Other (Specify)		Park Cemetery :\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	16-081	Baltimo	re, Maryland		
Kill I	1.11. 101	1041635	Slack Funeral Home	e. P.A.				
23a. Fart 1. Enter t	the disease, or complications that cause	ed the death Do not enter	3871 Old Columbia	Pike Ellicott C		Approximate		
hock, or hea Immediate Cause	art failure. List only one cause on each	line.	crotic CardioV		^	Interval Between Onset and Death		
dise se or condition resulting in death)	on a.		emile (argiov	ascaras	1) ( pe us			
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).								
cause. Enter Unde Cause (Disease or that initiated events	erlying							
resulting in death)	1	s a consequence of):						
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IF FEMALE:								
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an II. Other signi	ficant conditions contributing to death	but not resulting in the und	erlying cause given in Part I.		acco use contribute to			
				1 LI Yes	2 □ No 3 □ Pr	obably 4 Unknow		
				24a. Was an autopsy	prior to a	topsy findings available completion of cause of		
				perform 1 ☐ Yes 2	ed? death? 1 ☐ Yes	2.□No		
25. Was case refer examiner?	Hospital:			ath (Check only one				
1 ☐ Yes 2 ☐ 7. Manner of Deat	1 □ Inpat	ient 2 ER/Outpatient	.,	lome 5 Resider	ice 6 ☐ Other (Spe	cify)		
1 Natural	5 ☐ Pending (Month, D	ury 28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe hov	injury occurred			
2 ☐ Accident 3 ☐ Suicide	investigation  6 Could not be  28e Place of In	jury - At home, farm, stree		28f Location (Ct-	eet and Number or Ru	imi Pouto Mumbos		
4 🗌 Homicide	determined building, e	tc. (Specify)	is idotory, office	City or Town,		пат поисе <i>нитрег</i> ,		
29a. Certifier	Certifying Physician: To the bes	t of mv knowledge, death	occurred at the time, date and place	e and due to the ca	use(s) and manner as	s stated		
(Check only one)	Medical Examiner: On the basis and manner s	of examination and/or inve	estigation, in my opinion, death occi	urred at the time, da	te and place, and due	to the cause(s)		
29b. Signature and			29c. License number	29	d. Date signed (Monti	h, Day, Year)		
•	80/a	noh	D 30641		December	15 200 8		
0. Name and addr	ress of person who completed cause of	death (Item 23a) (Type. Pr	D 30641 Back Rived na	-				
*C	amerh Sabapath	1 201-109	Back River nee	t Road	Baltim	ove Mayla		
1. Date filed (Mon		rar's Signature	711-01 114	,		124		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** November 9, 2008 4:41 PM M Kenneth Seward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1448 Aisquith Street 1st flr Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F 216-78-8379 June 30, 48 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r then "natural", or items 23s or 28s-f shov the Madical Examiner must be notified at Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1448 Aisquith Street 1st flr 21216 USA 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: black. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk e filed withir al Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 12 should be fi h and Mental F 7 is marked ot unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Baltimore City Police Dept s 1 and 2 f Health a item 27 is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
important: if iten
any injury or oth Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ₺ Othex (Specify) in State 21. Signature of Funeral 16 State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a. Human MMUNODEFICIENCY VIRUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit Exami Due to (or as a consequence of): Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown م signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Ś licate has been sig r, page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Record Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No Vital 1 Yes 2 No us after death.
urs after death.
verai Director: After this cen...
by the funeral director, pr 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA ð 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 10, 2008 MEDICAL DOCTOR D0063501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 PREDERICK RD. SUITE 162 CATONSVILLE MA RABINA MALIK Registrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 10, 2008 **Physician** 5:05 AM M Henry Schmalbach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Edenwald If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 F 1915 Maryland 212-07-7736 93 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the "Nescal Examiner or ust be confired an once. 1 ☐ Yes 2√☐ No Director Towson MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 800 Southerly Road #113 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black White etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No white \$ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) accounting financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ( Ida Amelia Muller Henry Schmalbach ပ 19a. Informant's Name/Relationship (Type. Print)
Martha DeGreif/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 B Fremont Street Bloomfield, NJ 07003 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Ronald S <sup>22</sup>State Anatomy Board 655 W. Baltimore Street censee d Director Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre or heart failure. List only one cause on each line. 23a. Part shock Approximate Interval Between Onset and Death Immediate chise (Final disease or condition resulting in death) Physician /Medical Due to (or as a lonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C

State Registrar

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Medical

December 10, 200

29a. Certifier

(Check only

29b. Signature and title

30. Name and addre

of certifier

WA 31. Date filed (Month, Day,

completed cause of de

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:15 A M 18, 2008 Dec. Martha Katherine Salter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Millie's Place Assisted Living Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 22, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year) 1911 1 □ M **X** X F Maryland 97 212-38-0149 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f sho 1 ☐ Yes XXNo Director Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. by Funeral 9801 Lyons Mill Rd. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or items the Medical Examination 11. Marital Status Black, White, etc. XIXNever Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse Ifth and Mental Hygier
27 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Elizabeth Seaman William Henry Salter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 9725 Lyons Mill Rd. Owings Mills, MD 21117 Thomas W. Hardy 20b. Place of Disposition (Name of cemetery, crematory of other place)
Druid Ridge
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition ò XXBurial 2 Cremation 3 Removal from State permit. Page Department c Important: If any Injury or once. 12/22/08 | Pikesville, MD 4 Donation 5 20ther (Specify) 21. Signature of Fane al Se Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 nn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** enelesouascula /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Denente 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1∐Yes 2⊠No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 Homicide e Funeral Filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rec) ten stown bch MA-Minkong 750

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State

Registrar

31. Date filed (Month, Day, Year)

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DARKE!

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 26,29d per doc g886 12-19-08 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10 AM recember 12,2008 /Medical give street and number) 4a. Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Hours I Min. (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months 80 Yrs. Director August 14, 1928 Usual Residence of Decedent 10h. County 10c. City, Town or Location with the Maryland 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examination that is not all the angular and injury or other traumatic event, If a Medical Examination in a process. 28a-f show 1 Yes,2□No Be Completed by Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Aymed Forces?
1 Yes 2 No IVes Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Bla 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) remical. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blair North Balto daughter HVE 141) 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State var16Hc 4 Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Lice ree Howell Home Balto MD 2120 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ne Sequentially list conditions, it are the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner consequence of law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): # to ≠ to the box 68760, Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 🙀 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director and the funeral director. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 □ Yes 2 □ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12-14-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Ad; cations Ville up all 413 commond 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** December 3:00 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burni +nne Gen Hrunde 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 ☐ M 2 1 F Months Days Hours Min. 219-26-4195 NOV. Virginia 12, 1940 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State Department of Health and Mental Hygiene. important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exycitist must be rediffed at once. 1 Yes 2 No **Funeral Director** Hruude thine er Burnie -10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21060 116 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Giv Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 2 Married 1 Never Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) verizor phone 18. Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (First, Middle, Last) Be Harris Kobersor Malidi ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Hen Burnie, 116 MD 21060 ames outton Country 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20108 Baltimore 21. Signature of Funeral Service Licensee 4600 21207 MD Approximate Interval Between Onset and Death 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** Due to (or as a configuence of): disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). Ecquentially list econions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tran and Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ M0 24a. Was an autopsy 1 □Yes 2 ☑No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 No 1∐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient -9 ☐ 24 hours after death.

Funeral Director: After this letely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier mun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOV 31. Date filed (Month, Day, Year) Agistrar's Signature State Registrar -

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month X CLINTON DECEMBER 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE REHABILITATION EXTENDED GARE BACTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 212-20-3791 83 April 4, 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 🛣 No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2057 Harman Avenue 21230 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Affiled Forces 1 [X]Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 🖁 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Dry Ice Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Sexton Rosa Boggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2057 Harman Avenue Baltiomre, MD 21230 Mrs. Noreen Sexton/Wife Date 21, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sington Funeral & Cremation 21. Signature of Funeral Levies Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 Molago. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final VASCULAR ACCIDENT CEREBRO disease or condition resulting in death) Due to (or as a consequence of): Due to or as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 □ No 2. NO 26. Place of Death (Check only one)

Physician /Medical Examiner

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Department of Important; If any injury or once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "heckeal Evernine must be notified at

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

the Maryland

Examiner

Physician/Medical Completed by Be Certification: To

physician and the burial-transit attending p signed by the a d be detached for ate has bade 2 s this certificate director,

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

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State Registrar

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

29c. License number

D30272

29d. Date signed (Month, Day, Year)

MARYCAND

DECEMBER 16, 2008

DEC 1 9 2008

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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miller into

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edward W. Steinnagel, Jr. :23PM December 10, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Homore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days 214 52 8439 59 Director 09/07/1949 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7765 Freetown Road 21122 U.S.A. or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked, any injury or other traumatic evonce. Edward W. Steinnagel, Sr. ဂ္ Lorraine M. Goodrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anthony Micriotti / cousin 408 Cockeysmill Road Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2008 Baltimore, Maryland Lorraine Park Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sonly one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final espirator Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PUNCHIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 □Yes 2 □No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 50 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform era bea 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the burial signed by the a Id be detached for this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

filed within 72 hours after death with the Maryland

Pages 1 and 2 should be filed withir

Maryland

Baltimore,

22

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of confifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Medical

			For State Registrar	State of Ma	aryland	-	artment of F r <i>tificate of I</i>			giene Reg. No. 🔿 🕜	17 17	10710
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Vera M. Sherick						Decembe	r 14, 2	008	6:20 PM
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or Rockvil	Location of Death		4c. County		***
6"	Funeral		805 East Jeffers  5. Social Security Number 6. S		e (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	_	9. Birtho	place (State or Foreign
	Director		314-30-4965	□M 2∏F	78	Yrs.	Months Days	Hours Min.	May 11	, 1930	Indi	ana
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryla f sho	tor	Maryland Montgome	ry	Rockv							1∭Yes 2□No
	r 28a-	Director	10e. Street and Number		<u> </u>		10f. Zip Code	^		10g. Citizen of V	/hat Cour	ntry?
	th with	ralD	805 East Jefferson	Street			2085	2		United :	State	es
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, It in Actal Francing must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	l l	e - Americ k, White, Whi	
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/lar	ould be Mental arked o atic eve	To B	George Grover Ower	ıs				Jessie H	logan			
, Mar)	ges 1 and 2 should be filed v nt of Health and Mental Hygie If item 27 is marked other t or other traumatic event, the		19a. Informant's Name/Relationship ( Marcia E. Kennedy	Type. Print) /Daughter			ng Address <i>(Street</i> 2 Sage Wa					
altimore, Maryland 21215-0036	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 🛱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cen	netery, cřel	sition (Name of matory or other place Crematoriu	e)   Decem	pate ber 17,	20c. Location - Bethes		own, State Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	M0154		30		gomery Ave	nue, Rock	ville, Man		nc.   20850-2805
	Physician	5 2	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lir			ter the mode of dying	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Years
/Medica Examine			resulting in death)	Due to (or as	a conseque	nce of):						
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	nce of):					_	
YX	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C							-	
90	ificate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):						
68760,	ficate physi s the t	edical		d								
O. Box	The law requires that the death certifi site has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			e of deliventh	ery Day Year
۵.	that the		Part II. Other significant conditions of	contributing to death b	ut not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to t	he cause of death?
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<u>=</u>	; The law cate has , page 2 s	Con							perfo 1 □ Yes		death? I∐Yes	2 🗆 No
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0	g Phy er this eral di	n: To	27. Manner of Death	28a, Date of Inju	ıry 2	8b. Time c		er: 4 □ Nursing H y at		dence 6 ∐Oth now injury occurr		fy)
Ö	ending rath. or: Aft he fun	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation		iy, rear)	Injury		k? Yes 2□No				
Division of Vital Records,	I or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju	ury - At hom c. <i>(Specify)</i>	e, farm, st	eet, factory, office		28f. Location (8 City or Tov		er or Run	al Route Number,
	To the Hospital or Attending Physician; within 42 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, r	Medical C		nysician: To the best niner: On the basis o and manner st	of examination							
	To the within To the comp	Me	29b. Signature and title of certifie	1 1		7111	29c. Licens			29d. Date signe		
			<b>&gt;</b> ///	////		VVI	D3845	<i>'</i>		Decembe	1. 12	, 2006
	9		30. Name and address of person who Nakul Goyal, M.D.	3801 Int	ernati	lonal	Drive, #	211, Silv	ver Spri	ng, Mar	yland	1 20906
	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signatu	dogs.	E.J					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Emma Jean Smith December 14, 2008 2:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 89 Director 496-01-3724 Jan. 29, 1919 Missouri Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 X No Prince George's Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ŏ 3156 Gracefield Road #213 20904 items 23a United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 □Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ▼ No Specify. ģ Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental James Daniel Blackwell Ada Belle Foxworthy ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Raymond Smith, Jr./Husband 3156 Gracefield Rd.#213, Silver Spring, MD 20904 item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth December 18 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State rium, Inc. 2008 Bethesda, Maryland
Robert A. Pumphrey Funeral Home/Chase. Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO198 7557 Wisconsin Ave., Bethesda, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 XNo Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 21X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 ☐ Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D59524 December 16, 2008

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year, DEC 1 9 2008



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	-	State of Maryland / Department of Health and  1 - State Registrar  Certificate of Death				Wental Hygiene			
		Hegistrar  1. Decedent's Name (First, Middle, Last)				0 Data - (Data)			
Physicia /Medic		Doris Elizabeth Schmidt				December			
Examine	er	4a. Facility Name (If not institution, give street and number)  1055 W. Joppa Rd. #318	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 ☐ M 2 ☒ F 94	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 24,	<sup>(ear)</sup> 1914 Ma	rthplace (State or Foreign ountry) aryland	
t. Pages 1 and 2 should be filed within 72 hours after death w frnent of Health and Mental Hyglene. tant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Exit ciliner must	ō	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           MD         Baltimore         Towson						10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	Director	10e. Street and Number 10f. Zip Code				100	. Citizen of What C	ountry?	
	rai	1055 W. Joppa Road, Apt. 318		21204			U.S.A.		
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His fYes, specify Cubar I∐Yes 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Lhite		
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	ပ္ပ	4	Home	Maker	19 Mother's Name	e (First, Middle, Ma	Own Ho	ome	
	To Be	17. Father's Name (First, Middle, Last)  Luther Elwood Gerwig					e Gunther		
	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ling Address (Street and Number or Rural Route Number,			City or Town, State, Zip Code)		
		Richard D. Irvin / Son	_	20 Old Yor			Maryland  oc. Location - City of	211 31	
		1 Burial 2 ☐ Cremation 3 ☐ Hemoval from State 4 ☐ Donation 5 ☐ Other (Specify)	vikm	sition (Name of natory or other place Memorial	12-22	-2008 5	Sykesville	e, Maryland	
permi Depar Impor any ir		21. Signature of Funeral Service Licensee	1 22	Ruc Ruc 105	k Towson 50 York R	Funeral d. Towsor	Home, Inc n, Md. 21	204	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and to point of the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ent					Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition resulting in death)  a. Sep 5   5   day 4							
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	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown							
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	Medical Certification: To Be Completed	Atrial triby 1 1 yes 2 400 15					prior to death?	completion of cause of	
		25. Was case referred to medical examiner?  26. Place of Death (Check only one)							
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		1 Natural 5 □ Pending (Month, Ďay, Year) 2 □ Accident investigation	Injury		? /es 2□No				
		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roundle City or Town, State) 28f. Location (Street and Number or Rural Roundle City or Town, State)						Rural Route Number,	
		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier  M  M  M  M  M  M  M  M  M  M  M  M  M	0	29c. License	number 9	290	d. Date signed (Mon	7-2008	
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  EVAN GELOS C. LIGNOS, 7801 YORK Rd. STE 102, TOWSON, MD. 21209							
Sta Registr	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature	9		ί	/	7	/ [	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15 2<u>008</u> DECEMBER **Physician** 11:55 P M SHENKER ALLAN В /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/09/1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) MD Months Days Hours Min 1 💢 M 2 🗆 F 220-24-6213 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 7935 STEVENSON ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other the any injury or other traumatic event, inc. once. PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHENKER PEARL MORRIS မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7935 STEVENSON ROAD, BALTIMORE, MD 21208 ROSALIND SHENKER / WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CONG. 12/18/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mule 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lymphoblastic Corkeine weeks ACUTE /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PILE 1 ∐Yes 2 X/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After th funeral 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Parson MD ZIZOX MO AAAON 6701 CHANKES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 20000 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER 17 REBECCA SILVERBERG 2008 2:15 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **POTOMAC** MONTGOMERY MANOR CARE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/15/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🔀 F POLAND Yrs 89 415-54-5952 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 ☐ Yes 2 No POTOMAC MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11405 BIG PINEY WAY 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. WHITE Specify: 3 XWidowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 **HOMEMAKER** OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZALMAN KORNFELD UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULA WISEMAN / DAUGHTER 11405 BIG PINEY WAY, POTOMAC, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State ERETZ HACHAIM 12/18/2008 ERETZ HACHAIM, ISRAEL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 TUCU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital:

**Physician** /Medical Examiner

physician

attending physic for use as the b

ed by the a

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital

this

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

Physician

Examine

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Medical Certification: To

Sequentially list conditions, if any, leading to infinite late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

☐Yes 2☐No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h Time of (Month, Day Year)

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D0054566

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhogavilu, 980, Creorgia Arnu # 1-17, Silversprim, mozago ouni tha

State Registrar 31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December 2008 Slattery Dorothea 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

7. Age (In vrs. last birthday)

79

Pasadena

Days

Months

If Under 1 Year | If Under 24 Hrs.

Hours

Min

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Anne Arundel

USA

White

Months

2 No

Year

07:15 PM

**Physician** /Medical **Examiner** 

Director

551 Riverside Drive

6. Sex

1 □ M 2 1 P

5. Social Security Number

214-26-6177

**Funeral** Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, It

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Examiner

Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans physician sthe burial as nse atter the signed by to d be detach cate has certificate this After the after death.

Director: A d in by the fu death.

Box 68760.

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of Vital Records,

Division

8. Date of Birth (Month, Day, Year) Sept. 21 1929 Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 551 Riverside Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Desk Clerk Library 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorthea Schultz Kellermann Frederick Α. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Flickner (daughter 556 Riverside Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc 2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain\_Road, Pasadena, MD 21122 23a. Part1. Enter the disashock, or heart failu ase, or complications List only one cause t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final ADD disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 [] Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burne MD 21061 305 KARL HO SPITA

State Registrar 31. Date filed (Month, Day,

Year)

e Funeral

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 15, 2008 **Physician** 10:47 AM Edward Lee Toles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov. 26, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F Months 75 224-38-0633 Virginia Ĩ933 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, it a Modical Examiner must be realified at MD Prince George's District Heights 1 ∏Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 6602 Evanston Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ 18-17-54 If Yes, Give, Year or Dates 8-1-57 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xuo Specify: ò Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Labor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unavailable) Viola Toles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth G. Toles - Wife 6602 Evanston St. District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Shiloh Old Site 12-22-08 Garrisonville, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility A.L. Bennett Funeral Home 21. Signatur of Funeral Service Licensee 200 Butternut Dr. Fredericksburg, Virginia Fart 1. In ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adio Vascular **Physician** Alberosclerot 54disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣️ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2**X** No 1 ☐ Yes 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient this After thi 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1'S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45365 N. / Type, Print)
1170/ (ivings for NO 14 10/ ft WAShipton
MD 20766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 9

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Bronwinne Beverly A. 2008 165 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Maryland Hospita Baltimore University of Maryland Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year) 213-81-6255 1 □ M 2 🗷 F Months Days Hours Min. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No n/a MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2022 E. 31st Street 21218 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give X Year or Dates: X Never Married 2 Married 1 ☐Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Damon Turner Bronwind Wynder 19a. Informant's Name/Relationship (Type. Print) Bronwind Wynder-Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (mother) 2022 E. 31st. St. Balto, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery Dec. 23, 2008 Anne Arundel 20a. Method of Disposition 1 Derial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Co. MD nature of Funeral Service Licens 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto. Md. Xmadene Preston St. Balto, Md. Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplete Arterioventricular disease or condition resulting in death) Due to or as a consequence of): halposition of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Double- outlet Right Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

**Funeral** 

Director

28a-f show

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Health and Mental Hygiene. em 27 is marked other than ther traumatic event, The M

Department of Health Important; If item 27 any injury or other troone.

Examiner must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examine burial-trans and Physician/Medical the attending pl sate has been signed by the page 2 should be detached Completed certificate director, Be Certification: To this funeral After death. within 24 hours after deatl To the Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760

2

Medical

Registrar

30. Name and address 22 31. Date filed (Month, Day, State

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one) 29b. Signature and 5 Pending

investigation

6 ☐ Could not be determined

e of certific	* [ ]	
4	"Wesch	1

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

SW 2120

00 0 Registrar's Signature 2008 19

Physician / Modelcal Examiner    Page   Physician / Modelcal   Physician   Physician / Modelcal   Physician   Physician / Modelcal   Physician   Phy	ate or Foreign unk  de City Limits Yes 2 \( \) No
S. Social Security Number   S. Sex   91   7. Age (in yrs. last birthoday)   10 under 1 Year   10 under 24 Hm.   10 under 24 Hm.   10 under 1 year   10 und	unk de City Limits
Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Description of the disease of condition resulting in death)  Description of the disease of conditions, if any, leading to immediate ovents resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician /Medical Examiner  23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate out.  Sequentially list conditions, if any, leading to immediate out.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
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Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Description of the disease of condition resulting in death)  Description of the disease of conditions, if any, leading to immediate ovents resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	e
Physician /Medical Examiner    Description   Physician / Medical Examiner   Physician   Ph	
Due to (or as a consequence of):	Between and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No   No   No   No   No   No   No	
# Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Year
so Sign a	
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27. Manner of Death   1	
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.	Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yes  D3 Yes Co  29d. Date signed (Month, Day, Yes  D3 Yes Co  29d. Date signed (Month, Day, Yes	
Robert Dut in D3 Please Declinary 9, 2  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert Dut 100 32. Begistrar's Signature  BEC 1 9 2008	use(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17, Jean M. Warren 7:35 P.M December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 ☑ F Months Days Hours Min. 86 Yrs. Director 148-18-9462 12/14/1922 New Jersey Usual Residence of Decedent Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination count to modified 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Cockeysville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 10337 Malcolm Circle Apt. M 21030 Funeral of America 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Armed Forces?
1 □Yes 2 □ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√No \$ Specify Specify: white 312 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Bluecross & College (1-4or 5+) 12 Data Entry Blueshield 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental His marked ot Louis Grant Parker, Jr. Anna Slye ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Fleming/ friend 106 Warren Road Cockeysville, Maryland 21030 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>=</u> ه Department of Important: If it any injury or o once. December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral 19, 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel Bel Air 119, 2000 Folest HIII, Maryland
22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service Licensee 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINSONS **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or sele incheequance of) attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No After this certificate 1 □Yes 2 □ No 1 ☐Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \( \hat{\mathbb{R}}\)Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Injury at Work? or Attending 5 ☐ Pending investigation ours after death.

neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D104395 DELEMBER 18,2008 completed cause of death (Item 23a) (Type, Print) CHAPLES ST, SUITE 209 BALTIMORE, MD 21204 DEERM AN, KO 6565 N Year) Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Las 2. Date of Death Physician 3, 2008 : 10 AM /Medical or Location of Death 4c. County of Death **Examiner** Kamse + more (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Hours 1□ M 2**X**F Director Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show MD 1 Yes 2 □ No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 JSA amseu by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event than "na once. (Give kind of work done during most of working life. DO NOT use retired) (Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, M Be usan ၉ Informant's Name/Relationship (Type. Print) Address (Street and Number or Rural Route Number, 18160 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 12.18.08 of Funer | Syrvice Liv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NU 7 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 □ yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 ☐ №0 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1∐ Yes 2∐Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral i 27. Manne of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 👱 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2907 16/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUANDA ed (Month, Day, Year) 3 N. ENTAW ST # 305 BALTIMONEMOUND HNAN 31. Date filed (Month, Day, 32 Registrar's Signature State DEC 19 2008 Registrar

DHMH 17 Rev 1/2001

**Physicia** /Medic **Examin Funeral Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Modical Examinar mant be rectified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar	Ce	rtificate of l	Death	Reg	. No. 2 (1) 8	1 40760			
sicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death			
edic		John Joseph Winebrenner			b	ecember		2:25 P M			
min	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	th			
		412 Secluded Post Circle  5. Social Security Number 6. Sex 7. Age (In yrs. It	ant histoday	Glen Bu		9 Date of Birth	Anne Aru				
rai tor		1 <b>☆</b> M 2□F	ast <i>birthday)</i> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )		thplace (State or Foreign ountry)			
101		215-60-2380 47 Usual Residence of Decedent			<u> </u>	11/19/19	61 [Mar	y <b>l</b> and			
4			, Town or Lo					10d. Inside City Limits			
	cto	MD Anne Arundel Gle	en Bur	nie				1⊠Yes 2□No			
	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?			
Maria	<u>r</u> a	412 Secluded Post Circle		21061		J	J.S.A.				
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White				
	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:		1 □Yes 2√x No	Specify:		Specify:	L o			
	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	16	Whi				
	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of working ()	g					
	Š	12	Wareh	ouse Labo	or	J	Inited Aut	o Workers			
	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Surname)				
	မ	Unknown	1		Unknown						
		19a. Informant's Name/Relationship (Type. Print) Gail Winebrenner/Ex Wife	19b. Mailii 4 Jes	ng Address <i>(Street &amp;</i> Ssie Court	and Number or Rural t, Reister	Route Number, C Stown, M	Dity or Town, State, 2 D 21136	Zip Code)			
			lace of Dispo	sition (Name of matory or other place	Da Da	ite 20	c. Location - City or	Town, State			
			nt Crem	ation Servi	$\stackrel{\sim}{=}$ 12/19/	2008 На	nover, Ma	aryland			
once		21. Signature of Funeral Service Licensee		2. Name and Addres	ALG		nation Ser				
	-	23a. Part1. Enter the disease, or complications that caused the death			-			Approximate			
		shock, or heart failure. List only one cause on each line.	†	1 1	S- C	)	''	Interval Between Onset and Death			
an al		disease or condition resulting in death)	CU E	HRAY	ralt	ure					
er		Due to (or as 1 consequence of):									
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence cause. Enter Underlying)									
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		resulting in death) Last Due to (or as a consequ	ence of):								
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	Ş	1 □Yes 2 □No 4 □ Fregulati at time of de 9 □ Unknown 9 □ Unknown	outi 5 L								
	7	Part II. Other significant conditions contributing to death but not result	lting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
	D Q	Hypertension				1 Nes	2 □ No 3 □ Pr	robably 4 🗆 Unknown			
	Completed by Physician	0 1				24a. Was an	24b. Were au	itopsy findings available			
	ē			_		autopsy performe 1 Yes 2	d? death?	completion of cause of			
	Be	25. Was case referred to medical examiner?			26. Place of Death		12.00	22110			
		1 Yes 2 No Hospital: 1 Inpatient 2 □ E	•		4 Unuising Hom	~	e 6 □Other (Spe	cify)			
	ö	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	Work		3d. Describe how	injury occurred				
	icat	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury. At hor	mo farm etr		Yes 2 □No	of Location (Ctra	at and Number D	- Courte Number			
	er	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,	)	eet, lactory, office	20	City or Town, S	et and Number or Ru State)	ıraı Houte Numper,			
	a	29a. Certifier 1⊈ Certifying Physician: To the best of my know	wledge, deat	h occurred at the tin	ne, date and place, a	nd due to the cau	se(s) and manner as	s stated.			
	Medical Certification: To	(Check only one)  2	ion and/or in	vestigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)			
	ž	29b. Signature and tyle of certifier		29c. License	number	29d	. Date signed (Monti	h, Day, Year)			
		Marine Marine		103	51596	Dec	cember 1°	7 2008			
		30. Name and address of person who completed cause of death (Item  K. Amborlavanar 7845 Oak  1. Dat filed (Month Day York)	n Bilirne	e MD.	21061						
Stat	e	31. Date filed (World, Day, Year)	urg	P		.,					
istra		DEC 1 9 2008	STATE OF THE								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number **Examiner** Himapa 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min 579.10 1 □ M Director Washington DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 271 Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after 1 □ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 5+ reading specialist education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Solomon Porte Meredith Lyon Department of Health and Men Important: If item 27 is marker any injury or other traumatic ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) William Wood/son 4 Fairview Drive Danville, PA 17821 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cree 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signa une of Funeral Serv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause Immediate Quse (Final disease or connection of resulting in death) Physician /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequince of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been signe 2 YU 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 20 No certificate 2 1 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at/ Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory; office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, D57028

State Registrar Aditya Chopra
31. Date filed (Month, Day, Year)
DEC 1 9 2008

30. Name and addre

Hertiage Harbor Hospital

Registrar's Signature

seof person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

21401

Annapolis,MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Esther Winston 2008 December 7. PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Prince George's Fort Washington If Under 1 Year | If Under 1 Months | Days | Hours | 8. Date of Birth (Month, Day, Year)
May 22, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number Days 1 □ M 2 X F 97 1911 Virginia 156-09-1973 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Prince George's 1 ☐ Yes 2 No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12201 Arrow Park Drive 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Estelle Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashin Howard/caregiver 210 Jennifer Drive Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signalure of Funeral Service Licensee te, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pall 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Repol Disease Due to (or as a consequence of): A 12176, mes Sequentially list conditions Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yes Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/**N**0 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician ģ certificate has After this Hospital or Attending

the burial-transit for use sate has been signed page 2 should be det funeral director, within 24 hours after death.

To the Funeral Director; A
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**Physician** /Medical

**Examiner** 

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

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Physician/Medical Examiner

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Certification: To

Medical

29a. Certifier (Check only one)

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

State Registrar

29b. Signature and title of certifier

DEC 1 9 19

cause of death (Item 23a) (Type, Print)

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Certificate of Death	Reg. No 2 0 0 8	4076	3
State of Maryland / Department of Health and Mental	l Hygiene		

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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08-09382 Charles Walton

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		3. Name and address of person w	o completed calle of deat	h (Item 23a)			-			
84		Theodore M. King, Jr., I	MD. Assistant Med	ical Examiner	111 Penn S	Street, Bal	Itimore, MD 2	1201		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHN B. ZABLOCKI 4:45 PM DEC. 16, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROSSVILLE FRANKLIN WOODS NURSING HOME BALTIMORE 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 219-18-2690 81 DEC. 19, 1926 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE **OVERLEA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5126 HENRY AVE 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify. WHITE Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 TRUCK DRIVER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN A. ZABLOCKI FRANCES BIALYZNSKI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE ZABLOCKI-WIFE 5126 HENRY AVE BALTIMORE, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 12/19/08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 6415 BELIAR RD BALTIMORE, MD 21206 23a. Par 1. Enter the disease shock or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to s a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

**Director** 

28a-f show

Director

by Funeral

Completed

Be

ed other than "natural", or items 23a or 28a-f sho event, the fluctoral Expriment must be notified at

within 72 hours after

12 should be filed w h and Mental Hygie.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 Is marked any injury or other traumatic ev

Baltimore, Maryland 21215-0036

/Medical

page 2 s

law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician:

Hospital or Attending

Examiner

Physician/Medical

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Certification: To

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physician attending p for use as t the signed by I

death. 24 hours after death Funeral Director: filled in by the

1 ☐ Yes 2 9 ☐ Unknown	No	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5 ☐ Other	(specify)		-	Month	Day	Year
	ficant conditions of	contributing to death but not resu	Ilting in the underlying	cause given in Part I.			se contribute		se of death?
						rformed?	24b. Were a prior to death?	completion	dings available n of cause of
25. Was case refer examiner?	red to medical			26. Place of D	eath (Check onl	y one)			
1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other: 4 Nursing	Home 5 ☐ Re	esidence 6	Other (Sp.	ecify)	
27. Manner of Deat  Natural  Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describ				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor)	ory, office	28f. Location City or 7	(Street and own, State)	Number or F	lural Route	Number,
29a. Certifier (Check only one)	1 Certifying Ph	nysician: To the best of my knowniner: On the basis of examinational and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to to curred at the time	he cause(s) ne, date and	and manner a place, and du	as stated. e to the ca	use(s)
29b. Signature and	title of certifier		2	9c. License number		29d. Date	signed (Mon	th, Day, Ye	ar)

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completely within 2

> JUde 31. Date filed (Month, Day, Year) State DEC 1 Registrar

7842 WD 32 Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muneres

9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Dav **Physician** NDERSON 7:45 P M HELENB 30 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CRESCENT CITIES CENTER RWERDALE PG COUNT GENESIS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | October 27, 1909 | Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2√FF 99 579-14-4143 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State D • C • Washington 1 TYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 211 47th Street, N.E. 20019 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 □Yes 2 No Specify à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Treasury Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Dean Brooks James Henry RObinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 47th Street, N.E. Washington, D.C. 20019 19a. Informant's Name/Relationship (Type. Print)
Keith A. Anderson (Grand-Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Park Dec.8, 2008 Laurel, Maryland 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's FUneral Home, Inc. 4217 9th Street, N.W. Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTHRITI 2 No 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a Was an autopsy perform 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Box 68760, P.0. signed by 1 be detach Division of Vital Records, peen has director, page 2 s certificate this funeral After 1

Certification: To Hospital or Attending within 24 hours after death. To the Funeral Director: A filled in by Medical

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at

filed within 72 hours after death with Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trailmeth.

**Physician** 

/Medical

Saltimore, Maryland 21215-0036

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> State Registrar

DHMH 17 Rev 1/2001

SAADIA 31. Date filed (Month, Day, Year)

DEC

29b. Signature and title of certifie

5 Pending

05

investigation 6 Could not be determined

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

HUSAIN 4409 egistrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

EAST WEST HWY

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exaginer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

0064208

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RIVEKDALE

Physician   Modelica   Examines   Security Name (in the interfactor), give sinest and number)   4a. Fixty Name (in the interfactor), give sinest and number)   4b. Clay, Town, or Location of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth   4c. County of Deeth	0757
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29a. Certifier  1	N- (-)
29a. Certifier   150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier   150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and time of certifier   29c. License number   29c. Lice	
29c. License number  29d. Date signed (Month, Day, Ye)  D22780  29d. Date signed (Month, Day, Ye)	מ
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
PETER SCHISSLER M.D. 7500 GREENWAY CENTER DRIVE GREENBELT, MARYLAND 20770	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DEC 0 8 2008	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 3, 2008 **Physician** Daniel Robert Burrier 12:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours 217-16-8511 85 Director 3, 1923 Maryland Apr. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Carroll County Nampstead Maryland 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3917 Shiloh Avenue 21074 United States Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Board of than, Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Education es 1 and 2 should be filed w of Health and Mental Hygier filtem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hester Long Raymond Allen Burrier 2 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3917 Shiloh Avenue Wampstead, Maryland 21074 Doris M. Burrier - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe Date 20a. Method of Disposition 20c. Location - City or Town, State Dec. 6, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 uns 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ON(R) disease or condition resulting in death) 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed' this certificate 2 No or Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Hespice Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death I Director: After to in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours after within 24 hours a To the Funeral I filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

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State Registrar Satish

31. Date filed (Month, Day, Year)

DEC 0 5

DHMH 17 Rev 1/2001

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Glown &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

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12-4-08

Rd., Westminster MD 21157

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Dire	5	10e. Street and Nui 5697 Bat		Court		10f. Zip Code 21703							Citizen of W <b>JSA</b>	Vhat Cou	untry?	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28d per me, g887,01730/09dhb Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** CHARLES BALOGH NOVEMBER 28 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Connecticut 7. Age (In yrs. last birthday) 81 Yrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 3km 2 □ F June 15, 1927 Director 045-20-1016 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ⊠Yes 2 □ No Director Fairfield Naugatuck 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 108 Clark Rd Unit 93 06770 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 123 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🖾 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Auto Supply Sales 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Mary Szucs Imre Balogh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 52 Oak Shade Rd, Gaithersburg, MD 20878 Deborah Dubeau/Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/2/2008 Frederick, Maryland Stauffer Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, 1621 21. Signature of Funeral Service Licensee opossumtown Pike, Frederick, MD 21702 Krodly P rt1. Enter ty dis-shock, or heart for Approximate Interval Between Onset and Death , or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only or cause on each line Immediate Cause (Final disease or condition resulting in death) Physician 100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): 一大の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10) の (10 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physiclan: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 27. Manner of Death 5 Pending investigation Probable multiple falls 1 Natural 1 ☐ Yes 2 No Mkrown 2 Accident じろそんじと DAMOCONO! 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 17th LOCUS To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa ure and title of certifier DO067210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nH

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 3 2008

ORIGINAL

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Richard Brown 12008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) SAINT HENES HOSPITAL BALT MORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Date of Birth (Month, Day, Year) Hours Days 1 → M 2 □ F Yrs. 200-09-6228 91 6/25/1917 PΑ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 715 Maiden Choice Lane CR 401 21228 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No 43— If Yes, Give Year or Dates: 65 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Officer US Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alonzo Brown Olive Messler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes W. Brown (Wife) 715 Maiden Choice Ln. CR401, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/3/2008 Glen Burnie, MD 22 Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Rd, Gambrills, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myo cardial infliction acrte hours Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed attending physician P.O. Box 68760 Records, Division or Vital Hospital or Attending Physician: 24 hours after death. ROUN

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f show ner must be notified at

9

"natural"

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

**Physician** /Medical

Examiner

the

Director

Funeral

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Completed

Be

Examine

Physician/Medical

Completed

Be

Certification: To

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral L Medical

State

29b. Signature and title of dertifier

29c. License number D47353

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12/1/2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S-Caton Avenue

Baltimore, Maryland 21229

TAICK, MO 31. Date filed (Month, Day, Year)

DEC 0 4 2008

6 □ Could not be

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dec. Year **Physician** 2008 1, 4:55 Рм Evelyn Peters Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton Convalescent & Rehab. Ctr. Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 20, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Virginia 1 □ M 2 □ XT 91 226-03-1958 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Odenton Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or USA 21113 501 Saltoun Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married OF 1 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peters Lilia Unknown Clarence ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Odenton. MD 21113 Zoe Draughon / daughter 2108 Brink Ct. 20b. Place of Disposition (Name of cematery, crematory or other place)
FORT HILL
Memorial Park 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/2008 Lynchburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 No 1 ☐ Yes 2 🔀 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No neral Director; A death. investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my onlines, death accurred. 29a. Certifie Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 2 address of person who completed cause of death (Item 23a) (Type, Print) (Mohth, Day, Year) State £ 2008 Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav **Physician** 21:08 P M 29 2008 David Michael Baum Nov /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Oct 18, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Maryland 219 72 4978 50 Ĩ958 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 □Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Walcal Evanter of the Demonstrate. Director MD P.G. Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9507 Nottingham Drive 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Yencha Joseph Baum ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Baum (Mother) 9507 Nottingham Drive, Upper Marlboro, MD 20772 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Lee Crematory Dec 4,2008 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee m01391 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATM-UTID Mourd. 1 ussine **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No icate has been si , page 2 should t Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 2 □ No 1 ☐ Yes 2 ZNo 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1/2 Watural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 003 Backinton Md xxxxxxx 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 05** 2008 Joseph Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar 2008 **Physician** 4:15 p Margaret Theresa Benedetti December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital Elkton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 M 2 F PA 90 198-01-2397 September 22,1918 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar is ust be motified at 1 Yes 2 No Director DE Kent Dover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19901 USA 106 Lotus Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à White 3 ☑ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 12 12 should be filed w th and Mental Hygiei 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elik Stefanik Anna Petrushka ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Department of Health Important: If item 27 any Injury or other tr. once. 27 Marianne Torres/Daughter 3049 Old Elk Neck Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 9, 2008 Dover, DE <u>Sharon Hill Memorial Park</u> 21. Signature of Funeral Service Lig 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 Approximate Interval Between Onset and Death Fart 1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Immediate Corre (Final disease or coolition resulting in death) **Physician** archire /Medical Due to (or as a consequence of): Examiner Divator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed reumonic attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) signed by the at d be detached for 1∐Yes 2∭XNo 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐Yes 2 ☑No this certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1X Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifi

Name and address of person

uhammeo 31. Date filed (Month, Day,

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who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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	4		Registrar  1. Decedent's Name (First, Middle, Last)		inouto or L		2. Date of De	Reg. No.	4115	3. Time of D	Death
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	/Medic	-3	Cecelia M. Brant  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			2008 unty of Death	4:26	A
1	Examin	er						Ca	rrett		
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36	rs aft I', or xami	by F	3 ₩ Widowed 4 Divorced Year or Dates:		1 □ Yes 2 □ <b>X</b> No	Specify:		Sp	ecify: Wh	ite	
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ğ	othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	Maiden Sur	rname)		
<u> </u>	should be filed within 72 hours after death with the Maryland and Mental Hyglene. In a marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	일	David W. Gilpin			Lilli	e Knox				
ar	2 sho and 1 is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or To	wn, State, Zip	Code)	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State	cemetery, crer	sition (Name of natory or other place	e)	Date	20c. Locati	on - City or To	wn, State	
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W.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)							30 de	rys
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m	deat	sicie	1 Yes 2 No 4 Pregnant at time of		Other (specify)		· · · · · · · · · · · · · · · · · · ·		Month	Day Yo	ear
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S,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not re $Pement T_i$	sulting in the u	nderlying cause give	en in Part I.	11		contribute to the		
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<u>≥</u>	after all in by	Certification:	4 ☐ Homicide determined building, etc. (Spec	cify)	,,,		City or To	vп, State)			,
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	e Ho 24 h e Fui letely	Medical	(Check only 2 ☐ Medical Examiner: On the basis of examinone) (1 P P P and manner stated.	nation and/or in	vestigation, in my o	pinion, death occu	rred at the time	date and pla	ace, and due to	the cause(s)	
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			30. Name an vact ress of person who completed cause of death (lite	em 23a) (Type,	Print)	9396. Friend	1				
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	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Sign	nature	and a						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year James Richard Booth December 2008 12:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Days Hours 61 Director 475-50-5877 Feb. 21, 1947 Washington, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show Maryland Montgomery Director Silver Spring 1 ☐ Yes 2 TxNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15301 Pine Orchard Drive, #2H 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X7 Yes 2 □ No If Yes, Give Year or Dates: 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Evarying 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Appraiser <u>Real</u> Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Booth Bessie Marie Grivas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Pepperman/Daughter 13107 Pickering Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page:
Department o
Important: If i
any injury or ō Burial 2 Cremation 3 Removal from State 8, Dec. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090] 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on me cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 30 minertes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify). 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 ☐ Yes 1 Yes in 24 hours after death.

the Funeral Director: After this certific holetely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕽 🗚 0 1 🗀 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the re and title of certifier 29d. Date signed (Month, Day, Year) romo 041 and address of person who completed cause of death (Item 23a) (Type O OMAS gistrar's Signature 31. Date filed (Month, Day, Year) State 2008

DHMH 17 Rev 1/2001

Registrar

3altimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 29, 2008 11:30aM Mary Η Bergeron 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Glade Valley Nursing Home Walkersville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6/19/1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Min. 1 □ M 2**X** F Vermont 79 015-22-3802 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State Frederick Thurmont MD1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21788 Apt.23 131 Cody Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manufacturing Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Smith Leon E. Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) Thurmont, Md. 21788 131 Cody Drive Apt.23 Richard O.Bergeron/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Crem. 12/02/2008 Beltsville, Md 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign hur of Fun all Servic License PANTOTOPO ADDIESPOT ADDIESPOT ADDIESPOT PANDO FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and 2 should be fil.
Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other traumatic even

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinal must be notified at

Examine Physician/Medical Completed by

Be

Certification: To

Medical

burial-tran and attending physician for use as the buria ed by the and or Attending Physician: 1 s after death. al Director; After this certifica ed in by the funeral director, p completely filled in by

The law requires that the death certificate be executed

Box 68760,

Ö

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Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 □ Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) address 61150N b

State Registrar

Day, Year) 05 2008



To the Hospital of within 24 hours at To the Funeral D Paldson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 26 State of Maryland / Department of Health and Mental Hygiene, State of Maryland / Department of Health and Mental Hygiene, 12/19/08dhb Registrar Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Bonnekser 2003 NON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anna If Under 1 Year 9. Birthplace (State or Foreign Country) Anne enter 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1 MM 2□ F 78 1929 Michigan 376-26-4868 Yrs Director Usual Residence of Decedent релтіт. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director N 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 207 606 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces r 1 Myes 2 □ No If Yes, Give Year or Dates: 5-11-51 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Woodward 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SCOOKS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Warren Bonnehsen atharpin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Church Cemetery 12-2-08 | Flux was vale 22. Name and Address of Facility Found and Sons Lee Funeral Chair 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee wM Sudley Rd. Manassas VA. 20109 M01080 SD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 3 ilater Immediate Cause (Final lears **Physician** weeks disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sequence of Due to (or as a co The law requires that the death certificate be executed physician and the burial-transit Box 68760. IF FFMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1 ∏ Yes 2 Dablo Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 □Yes 2 ∏ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO04051 12/1/08

State Registrar Medica

32. Registrar's Signature

PARKWay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Do has

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			State of Maryland / Dep		Mental Hygie	ene 2008	1.0770
			Registrar	rtificate of Death		. No. 5- 0 0 0	107111
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Will F. Currie	1.0		1, 2008	14:30 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	-
			Prince George's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Cheverly If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Geo	orge's place (State or Foreign
	Funeral Director		241-05-7222 1⊠ M 2□ F 93 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ea <i>r</i> ) Cou	htry) th Carolina
			Usual Residence of Decedent		MPLII 13	1913 NOL	ch carotina
	ylanc ylanc		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-fs	cto	Maryland Prince George's Fort Was	hington			1∭Yes 2☐No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	th wi		3421 Gennene Lane	20744	τ	Jnited Stat	tes
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte , or if		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐Yes 2 X No Specify:		Specify:	Black
Ö	hours ural"	Completed by	3 X Widowed 4 □ Divorced Year or Dates:	edent's Usual Occupation	16	b, Kind of Business/Ir	
<u>.</u>	"nat	lete	(Specify only highest grade completed) (Giv	e kind of work done during most of worl DO NOT use retired)	king	ib, Kind of Dusiness/ii	idustry
7	withi iene. <b>thar</b>	E C	Elementary/Secondary (0-12) College (1-4or 5+)	vy Equipment Opera	ator	Private	
0	filed Hygi Sther ent, I	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
an	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Evanine must be notified a	To B	Lutheran Currie	Gracie	e Dudley		
<u> </u>	shoul nd M mar mar	-		ing Address (Street and Number or Ru		City or Town, State, Zi	p Code)
Š	nd 2 alth a 27 is rtrav		Diane Brice - Daughter 342	l Gennene Lane Ft.	. Washingt	on, MD 201	744
Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20	c. Location - City or To	own, State
و و	Page: ento nt: If ny or		NE Burial 2 Li Cremation 3 Li Removal from State	Nat'l Mem Park De	ec 8. 2008	Raurel.	MD
≣	mit. I porta			2. Name and Address of Facility St			
ñ	any per		A I W NA . I S A I WAS BOOK I I WAS	4001 Benning Road,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or neart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	diovascular Diseas			Onset and Death
*	/Medical		disease or condition resulting in death)  a.   Typercensive Car Due to (or as a consequence of):	22014304441 21344			
	Examiner						
		Je	Sequentially list conditions, b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	cutec	Examiner	Cause (Disease or injury that initiated events c.				
oʻ	e exe ian ai ırial-t	Ä	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical	d				
9	ing pl	Med	IF FEMALE:				
. Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delive	ery Day Year
	e dea the at	sici	1 Tyes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Teal
0	that the de ned by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying equae given in Port I	23e Did toba	cco use contribute to	the cause of death?
Ś.	res the signe pe d	by	Part II. Other significant conditions contributing to death but not resulting in the	andenying cause given in Fart i.			bably 4 😾 Unknown
Records,	w requires s been sign should be	ted			I Lites	150	
ခ	law nasb	p de	ļ <del></del>		24a. Was an autopsy	24b. Were autoprior to co	opsy findings available ompletion of cause of
=	: The	Completed			performe 1 □ Yes 2√2	d? death? □No 1 □Yes	2 □ No
=======================================	Attending Physician: The lart death. ector: After this certificate haby the funeral director, page?	Be	25. Was case referred to medical examiner?		th (Check only one)		
1	Physical this call din	ပ္	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			ce 6 ☐ Other (Spec	ify)
ב	ding F h. After funer	io i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
Sign	death death ctor: / y the f	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm is	M 1 Tyes 2 No	20t Legation (Otro-		- / Barria Abrashas
Division of Vital	or Al after of Direc in by	Certification: To	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Roman Security Specify	reet, factory, office	City or Town,	et a <i>nd Number</i> or Rur State)	ar Houte Number,
_	Hospital 24 hours a Funeral t stely filled		29a. Certifier X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cau	ise(s) and manner as	stated
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and mayner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)
	->-0			D31528	Г	ecember 5	2008
	9		30. Name and address of person who completed cause of death (Item 23a) (Type				
12	2		Dr. Margaret Akpan 6128 Landover	Road Hyattsville,	MD 20785		
	Sta	te	31. Date filed (Month, Day, Year) DEC 0 8 2008  32. Registrar's Signature  April 10 10 10 10 10 10 10 10 10 10 10 10 10	· ·			
	Registr	ar	DEC 0 8 2008 Beaut & April				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician **GEORGE** CLINTON NOVEMBER 25, 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 229-33-2008 1**X** M 2 □ F 70 9/12/1938 Director LIBERIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD MONTGOMERY TAKOMA PARK 1 XYes 2 No 28a-f sh notified Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 7051 CARROLL AVE 20912 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items edical Exa⊞iner mu 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 ☐ Widowed 4 反 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 4 ACCOUNTANT PRIVATE marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othrany injury or other traumatic event Be JOHNETTE COOPER JOHN CLINTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7051 CARROLL AVE., TAKOMA PARK, MD. 20912 JOYCE CLINTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN 12/20/08 SILVER SPRING o Funeral Service Licensee 22. Name and Address of Facility 21. Signatu CAPITOL MORTUARY 1425 MARYLAND . N.E. WASH... Approximate Interval Between Onset and Death Enter the disease, or co plications that caused the death. Do one cause on each line nter the mode of dying, such as car Immediate Cause (Final **Physician** disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed physician an Due to (or as a consequence Completed by Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has autopsy performed certificate 1∐ Yes 2XNo Be 25. Was case referrexaminer? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. P.O. I Records, or Vital or Attending Physician: Division

Registrar

State

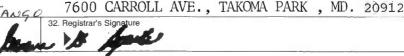
NASREEN 31. Date filed (Month, Day, Year) DEC 0 8 2008

and title of certifier

29a. Certifier

29b. Signature

Medical



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Midwed Center marydant 04 8. Date of Birth (Month, Day, Jul 25, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F 61 Months Days Hours Min 1947 Pennsylvania 214-48-3526 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. It a Martinal Emerican 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Thurmont Frederick 1 XYes 2 No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21788 13 Rouzer Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Factory Assembly Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Ridenour William Rice ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 Rouzer Court, Thurmont, MD 21788 Kimberly A. Cool, daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Scriptiffy, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/08/2008 Winfield, MD Carroll Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses 210 W Main Street, Emmitsburg, MD 21727 ust. 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Acute Resp ratery distress Due to (or as a consequence of): /Medical Examiner CoLecTomy Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit upper gastro in regtinal bleed Due to (or as a consequence of): Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) P.O. funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 NInpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) 29c. License number P-22936 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

WJL

GREEN ST

30. Name and address of person was completed cause of death (Item 23a) (Type, Print) M.D.

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32. Registrar's Signature

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EVIN

31. Date filed (Month, Day,

861531899 (NPI)

Registrar

Funeral Director

Division of Vital Records, I	w requires that been signed should be de-	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	To the Hospital or Attending Physician: The law requires that within 24 hours after death.  To the Funeral Director: After this certificate has been signed to the Funeral Director. After the certificate has been signed to the funeral director, page 2 should be dead to the funeral director, page 2 should be dead to the funeral director.	Be Completed	25. Was case referred to medical 26. Place of Death (Cl	24a. Was an autopsy performed 1 Yes 2 X								
	nyslci nis cer direct	To B	examiner?  1   Yes   2   No									
	ath. or: After the funeral		1	. Describe how in								
	Dir	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f.	Location (Street City or Town, Sta								
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.									
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	J. C.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RAKESH AROFA, MI) 14300 GALLANT FOX LN	,222,								
ı	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4 2008									
DH	MH 17 Rev 1/2	001	ORIGINAL									

		1 - State Of Wal	•	Certificate of L		R	leg. No. 2	8 40783					
Physicia	an	1. Decedent's Name (First, Middle, Last)  Dorothy C. Crim  2. Date of Death Month Day Ye Dec. 1, 20											
/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Dec.	4c. County of						
⊏xamın	er	Crofton Convalescent Center	?		Crofton			rundel					
Funeral			(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/31/1	Year) 9	. Birthplace (State or Foreign					
Director		054-16-0133 1□M 2XF	94 Y	rs.	Tiouro Ivani.	10/31/1	1914	Country) NY					
W		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits					
fsho	ō												
28a-	Director	10e. Street and Number		10g. Citizen of What Country?									
3a ol	<u>a</u>	2444 Blue Spring Ct.		21113			US	Α					
ems 2	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-		14. Race - American Indian, Black, White, etc.					
or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No.		1 □Yes 2□XNo	Specify:	riidari, oto.)		White					
ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:											
"nat	To Be Completed	15. Decedent's Education (Specify only highest grade completed)	(	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	lurina most of worki	ng	16b. Kind of Business/Industry						
iene. than		Elementary/Secondary (0-12) College (1-4or 5+)	)	memaker	,		Own home						
other other		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Surname)						
venta rked itic ev		Jacob Haupt			Lotlie Wolfe								
and I Is ma auma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
m 27		Warren Crim (Husband)		4 Blue Spri									
it of h		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State	20b. Place of C cemetery,	Disposition (Name of crematory or other place			20c, Location - Cit						
rtmer rtant: njury		4 Donation 5 Other (Specify) Atlantic Crematory   12/3/2008   Glen Burnie, MD											
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show upy njury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hardes ty Funeral Home P.A.											
		851 Annapolis Rd, Gambrills, MD 21054  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
voleien		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
ysician /ledical													
aminer		H-141		Nion				Years					
±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
and trans		that initiated events c.											
ng physician and as the burial-transit													
physics the I	Medical	d											
nding use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of		23d. Date of	of delivery								
d for a	icial	in the past 12 months?		Month									
by th tache	Physician/	1   Yes 2   No 9   Unknown 9   Unknown   1   Other (specify)											
igned be de	by F	Part II. Other significant conditions contributing to death but	23e. Did tobacco use contribute to the cause of death?										
een s	ted												
has b e 2 st	Completed	24a. Was an autopsy findings available prior to completion of cause of											
cate , pag	ပ်	performed?   death?											
certif	Be	25. Was case referred to medical examiner?  Hospital:		Othe	26. Place of Death								
er this eral di	2	27. Manger of Death 28a. Date of Injury	28b. Tir	me of 28c. Injury	at Nursing Ho		ence 6 Other ow ow injury occurred	(Specify)					
rtn. r: Affe e fune	ation	1 Natural 5 Pending (Month, Day, 2 Accident investigation	Year) Inj	ury Work M 1□	? Yes 2 □No			y osounou					
ector ector by th	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur	y - At home, farn	n, street, factory, office	1:	28f. Location (Street and Number or Rural Route Number,							
rsam al Din led in	Cer	building, etc. (Specify)  City or Town, State)											
within 24 nouts are readen.  To the cuneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier  (Check only one)  17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the	ž )	29b. Signature and title of certifier	n M	29c. License	number	2	12/2/0	Month, Day, Year)					
		30. Name and address of person who completed cause of dea	ath (Item 23a) (T	ype, Print)	- 6		7 70	3					
L/A		30. Name and address of person who completed cause of dear RAKESH ARUFA, MD	14300 (	MALLANT	FOXL	N,222	ISOMI	EMD20715					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan	•	artment rtificate			and M	lental Hyg	giene Reg. No. ?	១០១	1.0701.
	Decedent's Name (First, Middle, Last)										2. Date of Dea	th		3. Time of Death
Physician Margaret Cockrell										Nov.	30,	, 2°008	2:25 PM	
Examiner 4a. Facility Name (If not institution, give street and number						′			4b. City, Town, or Location of Death			4c. County of Death		
-			Corsica Hills			la at hirthday	If Under	trev:	ILLE If Under:	24 Hrs T	9 Date of Birt	Queen Annes		
	Funeral Director	ı.	5. Social Security Number 579-07-4727	. Sex 1 □ M 2 □ XF	7. Age <i>(In yrs.</i> 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 12/25/	Year)	Vast	place (State or Foreign ntry) nington DC
	ס		Usual Residence of Decedent											
	show		10a. State 10b. County			ty, Town or Lo							1	0d. Inside City Limits
	he Ma 28a-f	ectc	MD Queen	Annes		Stevens	10f. Zip					10a Citizo	n of What Cour	1 Yes 2 No
	with t	ä	10e. Street and Number  101 Tennessee	Road			101. Zip	216	566			rog. Onize	USA	itt y :
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar mast be notified at once.	<b>Funeral Director</b>	11. Marital Status	12. Was Deced		.S. 13.	Was Deced			gin? (Spe	ecify Yes or No-	14	. Race - Americ	
36			1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	1 Tes 3	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □Yes 2 X\ No <i>Specify:</i>			rican, etc.)		Black, White, etc.		
21215-0036	2 hour	To Be Completed by	15. Decedent's	15. Decedent's Education			16a. Decedent's Usual Occupation (Give kind of work done during most of w					16b. Kind	White 16b. Kind of Business/Industry	
215	thin 72 e. an "n		(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	(Give	kind of wor DO NOT us	k done di e retired)	uring most	t of workii	ng			
21	ed wil		10			Chief	Telep	-					on Corp	•
and	be fill ntal H ed oth		17. Father's Name (First, Middle, La John	rst) Thom	9 0	Muli	ısll		18. Mothe		(First, Middle,	Maiden Su	<sub>(rname)</sub> Green	
Maryland	thould nd Me mark matic		19a, Informant's Name/Relationship		4.5	_		(Street a			al Route Numbe	r. City or T		Code)
Ma	alth ar 27 is er trau		Diane Marie Emr		ter		0	*			vensvil			
Baltimore,	es 1 a of He fitem rothe		20a. Method of Disposition 1	□ Removal from S	20b. F	Place of Dispo cemetery, crer	sition (Nam natory or ot	ne of ther place	9)	D	ate	20c. Loca	tion - City or To	wn, State
Ë	: Pag tment tant; I		4 □ Donation 5 □ Other (Spe	cify)	For	ct Line					/08	Bren	twood,	
Bal	permit Depart Import any Inj once.		21. Signature of Superal Service C	ensee			2. Name and ardest			•	me P.A.	12 R	idgely	21401 Ave ANN,MD
			23a. Part 1. En er the disease, or conshock, or heart failure. List on	omplications that ca nly one cause on e	ch line.				g, such as	cardiac o	or respiratory ar	rest,		Approximate interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-aA	110	ners a	emer	the					4	years
	Examiner			Due to (	as a conseq	uence of):								/
	icate be executed physician and sthe burial-transit	Je.	Sequentially list conditions, if any, leading to himselfact.	b. Dear to (c	F 28 B CUT 990	uence of):								
		Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c											
68760,		E E	resulting in death) Last  Due to (or as a consequence of):											
387	ficate physics the t	d												
Box (	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		es, outcome of pregnancy  Live birth 2□ Fetal death 3□ Ectopic pregnancy						23d. Date of delivery		ery	
. B	ed for		in the past 12 mehths? 1 ☐ Yes 2 K No	1 Tyes 2 No 4 Pregnant at time of death 5 Other (specify)								Month Day Year		
P.0	d by the etached	Phy	9 Unknown	sulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of de			he cause of death?		
Records,	Physician: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use a	Completed by	Hypertention	n	Zur but not res			idso give					No 3□ Prot	
၀၁	e law re has bee e 2 sho		Coronary artery disease								24a. Was autop	psy findings available mpletion of cause of		
<u>=</u>	sician: The certificate h rector, page										perfor	med2 2 No	death? 1 ☐ Yes	•
Vital	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o			
o	Phys r this ral dir	5.	1 ☐ Yes 2 ♣No 27. Manner of Death	1 ☐ Ir 28a. Date o	<u> </u>	atient 2 ER/Outpatier Injury 28b. Time o						lence 6 Other (Specify)		(y)
0	nding Phith. : After this funeral	Il Certification:	Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	n, Day, Year)	Injury	м		? ′es 2 □ I			,,		
Division	after death Director:		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer												nd manner as s	stated
		Medical	(Check only 2 Medical E	caminer: On the ba	sis of examina	ation and/or in	vestigation,	in my op	oinion, dea	th occurr	red at the time,	date and p	ace, and due to	o the cause(s)
_	North With Con Con Con Con Con Con Con Con Con Con	3	29b. Signature and title of certifier	MAN D	2/2 -		29c.	29c. License number				29d. Date signed (Month, Day, Year)		
	24	٢	11.	HEM	m			1/2	(1)	//				
	wa		30. Name and address of person w	ho completed cause	of Geath (Iter	n 23a) (Type,	Print)	anic	La	ne	Eastor	1. M	D 71	601
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	nout!	Jein		1-76	-u-/U	//	216	
	Registr	ar	DEC 0 4 2	008	uses l	1. See	rate 1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 3, Leonard Clayton, Sr. December 2008 10:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 212-01-7546 93 June 23, 1915 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at show 1X Yes 2 No Directo Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 106 Normira Ave. 21921 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 X No Specify: ģ Specify: 3 X Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Superintendent Auto Manufacturing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ant: if item 27 is marked ott Be Harry Clayton Laura Yost 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Clayton/Son 106 Normira Ave., Elkton, MD 21921 other t ortant: if item ? injury or other timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Charlestown Cemetery 12-9-2008 Charlestown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bal R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 23 / art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only rine cause on ach line. Immediate Juse (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a e detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed' 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check onl one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA this fureral 27. Magner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending ours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Decritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

DEC 0.8 2008

32. Registrar's Signature

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G

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Coleman Frederick Church, III 00:35a M 6 2008 December /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Home Worcester Berlin If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea. 4/27/1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 73 016-28-5899 MA **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be netified at 1 □Yes 2 X No Director MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 12034 S. Piney Point Rd. 21813 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married 1 Wes 2 ☐ If Yes, Give Year or Dates: UBSII CO Jeman 21215-0036 1 ☐ Yes 2 ☐ XNo Specify <u>}</u> Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any Injury or other traumatic event, the MagnoRe. College (1-4or 5+) Elementary/Secondary (0-12) Investment Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Coleman F. Church, II Alice Johnston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire J. Church / wife 12034 S. Piney Point Rd., Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 12/8/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Fart. Enter the disease, or com "tations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final UNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and itely filled in by the funeral director, page 2 should be detached for use as the burlat-transit nearly filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PEXTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENSTERN SHOFE DE, SALISBURY BA2+1 6/4 MD 21884 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#23bperMD, 12/5/08, EMW, Medicate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alan Gale CLIVE <sup>Day</sup>, 2008 **Physician** December 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 9129 Saffron Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 31 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**∑** M 2□ F Months Days Hours 1944 Director 381-44-7571 63 Colorado Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedical Exymiter must be profiled at 1 □Yes 2 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 20901 United States 9129 Saffron Lane Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥ MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Emergency marked other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Management Agency Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Florence Nathan H. Harry Clive 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W 1 and 2 s Health a 9129 Saffron Lane, Silver Spring, MD Ann Clive, Wife permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/05/08 Alexandria, VA 21. Signature of Funeral Bervice Licensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Prostate Cancer 5 years resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami signed by the attending physician and a betached for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2500 Remove
9 ☐ Unknown Ttem Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been się r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Attending 1-Matural To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After example telly filled in by the fun 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 😥 🗲 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 00059244 12-5-08 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11510 Old Georgetown Road; Rockville, MD 20852 Giselle Mery,

DHMH 17 Rev 1/2001

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Registrar

M.D.

2008

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Cabe 11100PM NEARNACION 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mondomen HOSPITA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Min. Hours 1 □ M 2 🖫 F Yrs. 89 1919 Philippines Feb. 04. 212-92-1886 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 13701 Monarch Vista Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: Filipino 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Δ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmen Liwag Gregorio Limiap 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13701 Monarch Vista Drive Germantown, MD 20874 Mary Anne Fletemeyer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Dec. 08, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Intombment Gate of Heaven Cem. 2008 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home witis 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death GMMUNI Due to (or as a consequence of): reumothers Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner law requires that the death certificate be execute

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. in a function once.

Baltimore, Maryland 21215-0036

burial-t attending physician for use as the burial the signed by t icate has t , page 2 sl certificate director, After this Director:

ر P.O. Box 68760, P.O. Box 68760,

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Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes 2 ☑No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signatur

31. Date filed (Month, Day,

nd address of person who com

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ted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	;	State of Mai	rylanc		rtment of t tificate of		vientai H	ygier Reg. N	LUU	8	40789
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	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical	29a. Certifier 1 Check only 2 M	ertifying Physic edical Examine	cian: To the best of er: On the basis of and manner state	examinati	rledge, death on and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the tim	ne cause e, date a	(s) and manne and place, and	r as stat due to th	ted. ne cause(s)
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	290	/	30. Name and address of p	person who com	pleted cause of dea	ath (Item	23a) (Type, P	rint)			10	1-100		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:45 P M Virgil Houston Davis, Sr. December 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1**X** M 2 □ F 077-07-9581 92 July 10, 1916 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 TXYes 2 □ No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7709 Morningside Drive, NW 20012 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≿()Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. **African** 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify American δ Specify: 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7.27 is marked other than "r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) years Podiatrist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I tnt: If item 27 is marked of Houston Edward Davis Katie McDonald 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgil H. Davis, Jr. - Son 11 Kentbury Court Owings Mills, MD 21117 permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Dec 10, 2008 Landover, MD 4 Donation 5 Dother (Specify) ature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part \ arter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Acute Renal Failure 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Severe Malnutrition 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 □No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

completely

within 2

(Check only

29b. Signature and title of certifier

Majid Rahmanianshahri, M.D. 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) DEC 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0063343

29d. Date signed (Month, Day, Year)

December 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Timothy Robert Dennington

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g887 1-30-09 vt State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William P. Davidson December 01 2008 0030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Carroll Hospital Center 5. Social Security Number 3847 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Director 295-16-<del>8347</del> Sept 04 1924 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location al Hygiene. other than "natural" or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 301 Shriver Lane USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Yes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Security Elementary/Secondary (0-12) College (1-4or 5+) Cryptologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be William Bailey Davidson Lucile Hillis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Hope Davidson/wife 301 Shriver Lane Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Columbia Gardens Cem | 12/05/2008 | Arlington, VA 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (mbo lism Physician Ulmanan week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Hrknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**o 1 Yes 2 → No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 ☐ Yes 1 Hipatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52035 WJL 1471VA 2005 WESTMINSTER MARYLAND 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE, STE203 MD 291 STONER 31. Date filed (Month, Day, 32. Registar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 0 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Marcus Nalle Edelen Certificate of Death 1- For State Reg. No Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Year December 11, 2008 1230 hrs Nalle Edelen Marcus Nalle Edelen Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles White Plains Jay Bee Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Washington Country) DC **Funeral** Months Davs Hours 1960 July 12. 1 X M 2 48 214 72 3308 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 'n 10a. State Upper Marlboro 1 Yes 2X No s 23a or 28a-f show e notified at once. 28a-f show Prince George's Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 14400 Mt. Calvert Road Spur 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 27 is marked other than "natural", or items amatic event, the Medical Examiner must be Armed Forces? Never Married 2 Married Yes <sup>2</sup>XX No White Specify 1 Yes XX No specify: If Yes, Give Year 4 XX Divorced Widowed à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) vernit Pages I and 2 should be filed within 72 hou bepartment of Health and Mental Hygiene.

vportant: If item 27 is marked orier yor other traumorie. during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Demolitian Tech Automotive 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bette W. Watts Ignatius G. Edelen, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z)(()70p) 19a. Informant's Name/Relationship (Type, Print ) Ignatius G. Edelen, Jr. (Father) 14400 Mt. Calvert Road Spur, Upper Marlboro,MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 2008 Clinton, MD Lee Crematory Dec 14, Other Specify Donation 5 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Sighture of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD M00257 aus the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medical Alcohol intoxication complicated by hypothermia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit #1,23a,P11,2/,28a-f, perme G887 1/14/09 TT Physician/Medical X AMENDED X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Day Live birth Fetal death 2 past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown 2 Cardiomegaly 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 V Yes 26 Place of Death (Check only one) 25. Was case referred to medica Be Other Hospital: examiner? Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 FR/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Certification: Yes 2 X No subject exposed to cold 1 Natural Pending 12/11/08 FD 12:30 pm. 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City At home, farm, street, factory, office building, etc. 28e. Place of Injury FD: white Plains, MD Lane 3 Suicide Could not be by railroad tracks Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 12, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#16a.PerFHPCC12-8-08cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:45 P M 04, December 2008 OLIVE MAE FLEMING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Days Hours Min 578 40 0415 80 Mashington DC Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fleam 278 and seed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examination and the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of Seat 1 Yes 2 No Director MID 10e. Street and Number 10g. Citizen of What Country? SA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Admirn PS (Practice) Assistant Elementary/Secondary (0-12) College (1-4or 5+) dminastrative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, J. Be Un-avail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hd 2078 20b. Place of Disposition (Name of cemetery, crematory of other Crematory of other Crematory) 20a. Method of Disposition 20c. Location - City or Town, State 12/08/0 1 ☐ Burial 2 X Cremation 3 Removal from State Alexandria 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rope Funeral Home 21. Signature of Funeral Service Licensee Forestville 4d 2014 5538 Mariboro Pike 23a. Part 1. Enter the disease, or conshock, or heart failure. List only mplications that caused the due the Do not enter the more of dying, such as cardiac or revo Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** No. /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and burial-trar consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the detached f 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24a. Was an autopsy performed? 1 □ Yes 2 🌣 No . Were autopsy findings available prior to completion of cause of death? has certificate 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural
Accident within 24 hours arter co...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined (3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed Month, Day 29b. Signature and title of certifier 29c. License number Year

State

filed (Month, Day, Year) DEC 0 8 2008

JAME\$

CATEVENIS,

3001 HOSPITAL DRIVE, 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

Registrar

CHEVERLY, MARYLAND 20785

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / D	rtificate of Death	Reg.	0000	19795	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Emilie Forlenza		2. Date of Death Month November	Day 2008	3. Time of Death 5:40 P M	
ree g	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	110 7 01115 01	4c. County of Death	J.40 I	
Area .			Crofton Convalescent Center	Crofton		Anne Arun		
	Funeral Director		5. Social Security Number  073-28-5540  6. Sex 1 □ M 2X□ F  7. Age (In yrs. last birthday)  96  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Young) April 17,	Year) Country)		
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation			10d. Inside City Limits	
	Maryl F sho	tor	Maryland Anne Arundel Crofton				1 X Yes 2 □ No	
	h the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?	
	23a cust b		1804 Roxboro Place	21114		JSA		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Everning must be nuitined at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 XNo <i>Specify</i> :	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.	
21215-0036	2 hour	ted t	15. Decedent's Education 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentian 16a. Decedentia	dent's Usual Occupation	. 16	b. Kind of Business/Ir		
215	within 72 iene. than "na the Medi	Completed	(Specify only highest grade completed) (Give life. I	kind of work done during most of work DO NOT use retired)	ing			
21	be filed within 72 ho ital Hygiene. d other than "natui event, the Medical			tician	e (First, Middle, Ma	Business O	wner	
Maryland		Be c	17. Father's Name (First, Middle, Last)  Franz Herbst	Pauline		adir bumame,		
ary	12 should be f th and Mental I 7 is marked oi traumatic eve	ပ္		ng Address (Street and Number or Ru		City or Town, State, Zi	o Code)	
	od 2 Ilth 27 i r tra		Frederick Seibold/ Son 1804	Roxboro Place Cro	ofton, MD	21114		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 20b. Place of Dispo	matory or other place)		c. Location - City or To	own, State	
Ë	t. Pages tment of tant: If it		4□Donation 5□Other (Specify) Atlantic	Crematory 12/3		Glen Burni		
Bal	permit. Pages Department of Important: If it any Injury or once.		puffyer?	2. Name and Address of Facility Rol 6000 Annapolis Roa	ad Bowie,	MD 20715		
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	i,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)					
	Examiner		Due to (or as a consequence of):				years years	
		Jer	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequenc	• T 1			jas	
	ecutec ind transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. ———————————————————————————————————	enosis			years	
60,	ifficate be executed g physician and as the burial-transit	a E	resulting in death) Last "Due to (or as a consequence of):				9	
68760,	ficate physis the	edical	d					
	= 0, G	M/U	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	⊒ <b>£</b> ctopic pregnancy		23d. Date of deliv	•	
O. B	Physician: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use.	Physician/M		Other (specify)		Month	Day Year	
٦,	ires that signed by d be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
rds	w requires been sig should be	ed b	Diabels Mellite	)	1 □ Yes	2 <b>2 №</b> 3 □ Pro	bably 4 🗆 Unknown	
of Vital Records,	law re as be 2 shc	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of	
<u>=</u>	an: The law rtificate has tor, page 2 8	Con			performe 1 □ Yes 2 5	d? death? No 1 □ Yes	2 🗆 No	
Z:	sician: certific rector,	Be	25. Was case referred to medical examiner?	O.U.	th (Check only one)			
of	ding Phys h. After this funeral dii	ا: <u>1</u>	1	f 28c, Injury at	ome 5 ☐ Residence 28d. Describe how	ce 6 Other (Specinjury occurred	ify)	
jon	ath. r: Afte	atio	1	Work? M 1 ☐ Yes 2 ☐ No				
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,	
	To the Hospital within 24 hours To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month	Day, Year)	
	CAN	7	* Kakehanola Mi	) ) 2010		12/2/0	8	
-	31170			GALLANT FO	XLN,	BONIEM	120715	
	Sta		31. Date filed (Month, Day, Year)  32. Régistrar's Signature,	Sparte				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 8 Albert Lee Fidler December 6:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Long View Nursing Home Manchester 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1**X** M 2 □ F Nov. 2, 213-28-9979 78 1930 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r than "natural", or items 23a or 28a-f show the M-vical Examiner must be notified at Manchester Maryland Carroll County 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 United States 4173 Rupp Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 9 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) public works/horticulture municipal public works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Bosley Charles Fidler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4933 Grave Run Road Manchester, Maryland 21102 item 27 l Donna J. Epps / daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o once. Dec. 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, Maryland Carroll Cremation 4 □ Donation 5 □ Other (Specify 2008 21. Signature of Funeral Service Lic-22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** intes resulting in death) /Medical Due to (or as a consequence of): Examiner ntenraclesi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown s been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 2 🗆 No 2 410 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 14 No Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 A Natural (Month, Day Year) To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 5

DHMH 17 Rev 1/2001

151

tory Street, Manches for MD21102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For	State	of Ma	ryland		artment of			ental Hy	giene		
			1 - State Registrar				Cei	rtificate of	Death			Reg. No.	100	1.079
	Physicia	ın	Decedent's Name (First, Middle	e, Last)							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	/Medic	_	Betty Elizab		end			4b. City, Town,	or Loogtion		Decembe	er 11, 2		12:15 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution  Dennett Road M	. 0	,	Home		0aklan		oi Deam				
	Funeral		5. Social Security Number	6. Sex			ast birthday)	If Under 1 Year	If Under		8. Date of Birt	Garı	9. Birthpl	ace (State or Foreign
	Funeral Director		216-30-2098	1 □ M 2 <b>X</b> F	77		Yrs.	Months Days	Hours	Min.	Month, Day) March 3	y, <i>Year)</i> 31 1931	Coun	1and
	Contains 5 Report		Usual Residence of Decedent											
	arylar show d at	_	10a. State 10b. County			10c. City	, Town or Lo	cation					10	od. Inside City Limits 1 ☑ Yes 2 ☐ No
	ne Ma 8a-f s	Director	MD Garr	ett		Sw	anton	1401 7: 0 1			1	10- 02	M O	Λ
	with the		10e. Street and Number	•				10f. Zip Code				10g. Citizen of		,
	s 23	eral	344 Swanton Ro	ad 12. Was De	cedent F	ver in 115	S 13 1	21561	Hispanic Ori	iain? (Sne	cify Yes or No-	United 14. Bad	e - America	
_	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed F ied 1 □ Yes	orces?			Was Decedent of if Yes, specify Cul			Rican, etc.)	Bla	ck, White,	
	ar, or	þ	3 XWidowed 4 Divorced	If Yes, C Year or	aive			1∐Yes 2∭XNo	Specify:			Specif	y: Whi	te
5	2 hou	Completed	15. Deceden	t's Education	D	Į	16a. Deced	dent's Usual Occu	pation	at of workin	og I	16b. Kind of B	usiness/Ind	lustry
7	thin 7	nple	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+	+)	life. I	DO NOT use retin	ed)					
7	ed wi ygier ner th ner th	So	12				Home	emaker &				Own F		
2	be fill stal H sd oth even	Be	17. Father's Name (First, Middle,	Last)								Maiden Surnar	ne)	
Ž	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	P	Loy F. Smith  19a. Informant's Name/Relations	hin (Time Print)			10h Mailir	ng Address (Stree			Ritchi		State Zin	Cadal
<u> </u>	d2sh than 7 Isr traur							D Street					. <i>31a1e, 21p</i> 1550	Code)
ת ע	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Jim Friend, So 20a. Method of Disposition	11		20b. P		sition (Name of matory or other pla	<u> </u>		ate	20c. Location		wn, State
Dallillo	ages ent of it: If ii y or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State			matory or otner pi emetery		12/13	/2008	Swanto	ın MT	•
	artme ortan injur		21. Signature of Funeral Service			Gec		2. Name and Addi David A			,			
Ď	permit Depar Impor any ir once,		Kathining	1 Auxis	FLC		1	David A 21 N. S	. Burd econd	St.	Funeral Oaklan	. Home, nd. MD 2	P.A. 1550	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	gaused each line	the death	n. Do not ent	ter the mode of dy	ring, such as	s cardiac o	r respiratory ar	rrest,		Approximate Interval Between
	Physician	8 Y	Immediate Cause (Final disease or condition	T	276	1		114						Onset and Death
	/Medical		resulting in death)				uence of):	. 1	14					geny
	Examiner		Sequentially list conditions,	b	\u,	010	7 d	Hyp.	erpl	45	0			year
	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Durit	o (or ds a	consequ	uence of):		,					•
	and -trans	Examine	that initiated events resulting in death) Last	c	n (nr as a	consequ	uence of):							
0000	cate be executed physician and the burial-transit		,	l Due !	0 (01 43 4	consequ	201100 017.							
ò	icate phys s the	dical		d										
X O O	certificanding plans as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome p	of pregna	incy					23d. Da	ite of delive	ry
ŏ	atter for u	ciar	in the past 12 months?			2 □ Fetal time of de		⊒Ectopic pregnan ⊒ Other <i>(specify)</i> .	су			1		Day Year
į	t the c by the achec	hysi	9 ☐ Unknown	9□Unl	nown						_			
, L	w requires that the death certific been signed by the attending p should be detached for use as.	by P	Part II. Other significant conditi	0		11	ulting in the u	nderlying cause g	iven in Part I	l.	23e. Did to	obacco use con	tribute to th	e cause of death?
ğ	equire en sig ould b		Ischemi	c per	me	NTI	4				1 🗆 \	Yes 2⊒No	3 ☐ Prob	ably 4 □Unknown
ecorus,	2 38	plet	Type II	Du	1 II						24a. Was		Were autoprior to cor	psy findings available inpletion of cause of
Ē	Physician: The law r this certificate has b ral director, page 2 s	Completed	Cerebi	ral 11	95	CU	Dar	Acc	der	the	perfo	rmed? 2DNo	death?	2□ No
VII.	Attending Physician: r death. ector: After this certific. by the funeral director,	Be (	25. Was case referred to medica examiner?							e of Death	(Check only o	nne)		
5	this c	P	1 Yes 2 No		Inpatier		ER/Outpatier	" 3 DOX				dence 6 □Ot		()
	ling l	ion:	27. Manner of Death  1 Natural 5 Pendir	ng (Mo	te of Injur onth, Day		28b. Time o Injury	W	uryat ork? ⊒Yes 2□		od. Describe i	how injury occur	rrea	
Vision	death ctor: / the	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	ce of iniu	rv - At ho	me. farm. sti	reet, factory, office			8f. Location /5	Street and Num	her or Rum	l Route Number,
2	after all placed in by	ertification:	4 ☐ Homicide determ	nined bui	lding, etc	. (Specify	y)				City or Tov	vn, State)	007 07 71474	riodic ivanibor,
_	spita lours neral	O		ng Physician: To t										
	To the Hospital or Attending Physician: The within 24 buts after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of anner sta		tion and/or in	ivestigation, in my	opinion, de	ath occurr	ed at the time,	date and place	and due to	the cause(s)
	To the To the To the To the To the To the COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING COTTING CO	Me	29b. Signature and title of certifie	r		_	A	29c. Licer	nse number	~0		29d. Date signe	ed (Month,	Day, Year)
			1 Church	Town 1	le	-0	40	_   17.	1413	54		121	11/3	2008
		10	30. Name and address of person	who completed ca	use of de	ath (Item	23a) (Type,	Print) / O	المراجا	X -	2-11	(a. 1)	MA	7100
		7	Kay! Danie	1/4/1/2	/ <u> </u>	<i>JU</i> (	094	Jalt t	10105	191	Valu	larrex (	INT	16120
100	Sta	ite	31. Date filed (Month, Day, Year,		Hegistra	ır's Signa	iure	1						

DHMH 17 Rev 1/2001

	Physic /Medi Exami	ca
	uneral irector	
e Maryland	8a-f show	ortor

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylanc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event, the Widdal Event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or other event or ot

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

_	State Registrar	State of Marylan	•	rtificate of		F	Reg. No.	38	40798		
n Il	1. Decedent's Name (First, Middle, Last)  Dr. Elizabeth L	ochner Gri	ffith			2. Date of Dea Month 12/1	L / 2008	Year	3. Time of Death		
r	4a. Facility Name (If not institution, give st 4909 Ridgecrest	reet and number) Ct.		Fre	Location of Death		4c. County Fre	of Death	ick		
	5. Social Security Number 103-30-8370 6. Sex	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	920	9. Birthp Cour Bav	place (State or Foreign htry) aria		
	Usual Residence of Decedent  10a. State  10b. County  Frederi		ty, Town or Lo	ederick				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No		
Direct	10e. Street and Number 4909 Ridgecres			10f. Zip Code	702		10g. Citizen of V	Vhat Cour	ntry?		
Be Completed by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 _Yes 2 No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Blace	can Indian, etc.			
leted by	3 X Widowed 4 □ Divorced  15. Decedent's Educa (Specify only highest grade)	Specify 16b. Kind of Bu	WII	ite							
Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5 +		kind of work done of DO NOT use retired  ysician	18. Mother's Nan		pharma Maiden Surnam		tical		
0	Hans Lochner					Polleir					
-	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town,	State, Zip	Code)		
	Laura Griffith (			Ridgec							
	20a. Method of Disposition  12 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Sher (Specify)	Mo	nocac	y Cemet	ery <sub> </sub> 12/	1		Lsvi	lle, MD		
	21. Signature in França Service picensee		P	OB 18	Middlet	own, MI	21769	lome	Approximate Interval Between Onset and Death		
	Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Ust only one cause on each line.  Immediate cause (Final disease or condition resulting in death)  a.     Cerebrovascular accident										
_	Sequentially list conditions, b.	b									
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq									
edica	d.			***							
Medical Certification: To be Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of o 9 Unknown	al death 3	☐ Ectopic pregnanc ☐ Other (specify)	,		23d. Dat Mo	e of deliventh	ery Day Year		
a by ru	Part II. Other significant conditions control previous cerebro	_	-		en in Part I.				he cause of death?		
тріете	hypertension					24a. Was a autop	med?   c	death?	opsy findings available impletion of cause of		
3	25. Was case referred to medical				26. Place of Dea	1 ☐Yes		I□Yes	2 □ No		
ם כ	examiner? 1 ☐ Yes 2 🔀 No	ospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatier	nt 3 DOA Oth	or.	ome 5 🔀 Resid		er (Specii	fy)		
ation: I	27. Manner of Death 1 IX Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	yat :? Yes 2 ∐No	28d. Describe h	ow injury occurr	ed			
Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)										
edical		cian: To the best of my kno er: On the basis of examina and manner stated.									
Ž	29b. Signature and title of dentifier			29c. Licens D34			29d. Date signed (Month, Day, Year) 12/3/2008				
	30. Name and address of person who com Dr. Irfan W. Has	ssen 801 To	11 Ho		., Fred	erick,	MD 21	701			
e r	31. Date filed (Month, Day, Year) <b>BEC</b> 1 0	32. Registrar's Signa	ature	Coule							

Sta Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended #5perFH FCHD, KS 12/1997 Figicate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician**  $A^{M}$ Wanda Geraldine Goff November 2008 :30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2₩ F Months Days Hours Min. 77 Director 1931 West Virginia March 14, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Evandrar must be notified at 1X Yes 2 □ No Directo Maryland Frederick Brunswick with the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 814 Fourth Ave. 21716 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify 2 White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Sigley Fave Funk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Milton H. Goff / Husband 814 Fouth Ave., Brunswick, MD 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/4/2008 Frederick, Maryland Resthaven 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert.1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading of in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I been signed by the should be detached ITIVES 2TNO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sh autopsy perform 1 □Yes 2 No 1 ☐Yes 2 ☐No or Attending Physician: director 25. Was case of red to medical examiner? Be 26. Place of Death (Check only one) Hospital: 121 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA After this Certification; To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD16428

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who co

31. Date filed (Month, Day

Casper

Cline,

MD

2008

300 West Ninth St., Frederick, MD 21701

pleted cause of death (Item 23a) (Typ

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day Year **Physician** Wanda Eileen Guy 5:55 A M December 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Moran Manor Nursing Home Westernport Allegany 8. Date of Birth (Month, Day, Aug. 7 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2000F 220-16-6549 84 1924 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** MD. Allegany Westernport 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Poplar 21562 St. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3571No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working , life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Secretary <u> 12</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alfred Guy Clark M. Estella ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Poplar St, Westernport, Maryland Angie Burgess/ friend Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12/16/ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Philos Cemetery Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wane 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** leng rongru /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Box 68760. by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy director, page 2 should be detached for in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No this certificate 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To nours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 2. Date of Death 3. Time of Death **Physician** Month Julia Giordano December 2008 2:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fox Chase Rehab. & Nursing Center Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 13, 9. Birthplace (State or Foreign **Funeral** Hours Year) 1 □ M 2**X** F Months Days Yrs 120-32-0713 Director 96 1912 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyciene. 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the "sedical Examinar nust by nutitied at Director 1 Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1756 Portal Drive, NW 20012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🕱 No Specify: Specify: White ģ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Michael Cardello ပ Antoinette Romanelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Justine Johnson/Daughter 1756 Portal Drive, NW, Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Dec. 9, St. Charles Cemetery 4 Donation 5 Dother (Specify) Farmingdale, New York 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Cardiorespiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Hypertension Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Duvito (unas a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Congestive Heart Failure resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Chronic Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2xtxtNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🙀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ★₩ Natural 2 Accident 1 ☐Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 063232 2/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Patricia Gomez, MD 31. Date filed (Month, Day, Year) DEC 0 5

**⊯**gistrar's Signature

32.

2008

15525 Shady Grove Road, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2008 **Physician** Month Day /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore (ente) Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, June 29, Birthplace (State or Foreign Country)
 PA Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min 1 M 2 □ F 67 207-30-6516 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐Yes 2 ☐ No East Berlin PA Adams 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17316 USA 55 Conewago Park Dr Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🕱 No If Yes, Give Year or Dates: 1 □Yes 2 □KNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 9 Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Ruth Blouse Paul Arthur Hartlaub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 53 Conewago Park Dr East Berlin, PA 17316 <u>Betty L. Hartlaub</u> wike 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 17, 2008 | Hanover, PA Rest Haven Cemeteru 22. Name and Address of Facility 21. Signature of Funeral Service Lig TSG Feiser Funeral Home, Inc 306 Harrisburg ST East Berlin, PA173 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final tra cerobral disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or se a noneequenes of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2, No 2 No 1 □Yes 1 Tyes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Funeral** 

Director

28a-f show

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"natural", or items 23a

the Medical Examiner rivest be notified at

death with the Maryland

within 72 hours after

1 and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than "

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once.

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

sician and burial-tran attending physician for use as the buria certificate director

Hospital or Attending Physician: The law requires that the death certificate be executed After this funeral dir 24 hours after death. Funeral Director: Aff letely filled in by the fur the 2

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Medical

28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signatur 2008 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** rmar 30, 2008 November /Medical 3:45 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 200 South Southwood Ave. Annapolis 8. Date of Birth April 25, 1933 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **X**XM 2□ F Hours Min 75 483-32-2754 Director Towa Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at Director ¥XYes 2 □ No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21401 United States 200 South Southwood Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Vortes 2 □ No Kryes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married Married 1952-Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2XXX No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 1956 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grant Analysis U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H item 27 Is marked off Be Edith Bell Shunke Barclay Watson Heald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312B Cross Green St. Gaithersburg, Maryland 20878 Mara S. Link / Daughter permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/3/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician , /Medical Due to (or as a consequence of): Examiner 40641 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or a consequence of) or Attending Physiclan; The law requires that the death certificate be executed j physician and Due to (or as a consequence of): Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.0. the ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ⋛ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an certificate has autop-performed No page Division of Vital 1 □ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 5 Residence 6 ☐ Other (Specify) After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 □Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated.

(frem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar

0

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of Health Certificate of Death		ental Hygie	4000	40304
	q		Decedent's Name (First, Middle, Last)	:	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Katherine B. Hilbert	1	November	27, 2008	11:10 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Annapo.	olis		4c. County of Deat Anne	Arundel
	Funeral Director		213-66-3811 1 M 2 M F 54 Yrs. Months Days Hour	1 -	B. Date of Birth (Month, Day, Young) May 7, 19		nplace (State or Foreign unity) nington, DC
	land w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f sho	Director	Maryland Anne Arundel Annapo	olis			1⊠Yes 2□No
	th with ti	al Dire	10e. Street and Number 501 First Street 21403	3	10g	Citizen of What Co. U.S.A.	*
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other treumetic event, it a Medical Energial retrinest to colling any injury or other treumetic event, it as Medical Energial retrinest to colling any injury or other treumetic event, it as Medical Energial retrinest to colling any injury or other treumetic event, it as Medical Energial retrieves.	Completed by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Is Was Decedent of Hispanic If Yes, specify Cuban, Mexifor Specify Cuban, Mexifor Year or Dates:		ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: V	
21215-0036	72 ho "natur	leted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mile, DO NOT use retired)	most of working	7	. Kind of Business/	ndustry
7	l withir iene. r than	omp	Elementary/Secondary (0-12)  College (1-4or 5+)  Programmer Analy		- I	S. Naval	Academy
and	should be filed nd Mental Hygie marked othar ametic evant, L	To Be C	17. Father's Name (First, Middle, Last)  Charles J. Bartlett	other's Name (	(First, Middle, Mai (unknowr		
Maryland	and 2 shou ealth and M n 27 is mar	-	19a. Informant's Name/Relationship (Type, Print)  Stephen L. Hilbert/husband  19b. Mailing Address (Street and Nur  501 First Street				<sup>(ip Code)</sup> 21403
Baltimore,	of Hea of Hea fitam		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Da		. Location - City or	
E E	Pages Iment of tent: if it		4 Donation 5 Other (Specify) Hillcrest Memorial Gar				-
Ball	permit. Departr Importe any inji		21. Signature of Foreral Service Licensee 22. Name and Address of Fa				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
900	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ncer			1.5 years
	Examiner						
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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8760,	ate be		d				
Box 68	certific nding p use as	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
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	ires that signed b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.	23e. Did tobac	co use contribute to	the cause of death?
COL	w requir	oletec			24a. Was an	24b. Were au	topsy findings available
Vital Records,	The la	Completed			autopsy performed 1 Yes 2	d? death?	ompletion of cause of 2 \( \text{No} \)
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sion	Attanding ir death. actor: After by the funer	atlo	2 Accident investigation M 1 Yes 2	2 □No			
Division of	or Atti	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28	St. Location (Stree City or Town, S	t and Number or Ru ltate)	ral Route Number,
	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical Ce	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, or the basis of examination and/or investigation, in my opinion, or the basis of examination and/or investigation.	te and place, and death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To tha I within 2 To tha I complet	Med	29b. Signature and title of certifier 29c. License numb	ber		Date signed (Month	
}	->-		Marine Weins, MD D5283		٨	Ovember	27,2008
	100gg		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Planima Werner, MO 19W Bist gate Road #300  31. Date tiled (Month, Day, Year)  DEC 0 3 2008	A	20.115	m0 7	401
	Sta	ite	31. Date tiled (Month, Day, Year) 32. Registrar's Sprature	1-147	1 213		/ "
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= State Registrar All	nended	#4a pe	r MD	FCHD	Cert	tificate of	Death	tam	12/4/0	Reg. N	o. 21	10	9 40	180
. Decedent's Name		-	-					o came	2. Date of D				3. Time of	Death
JACOUE	LINE	BLUNT		HA	ALL				Month Decembe		ay 1. 20	Year 108	4:43	РМ
a. Facility Name (If		n, give street a	nd number)			4b. City, Town, o	r Location	of Death			c. County		:h	
ASBURY M	ETHOD I	ST VIL	AGE	Ave.	ussell	GAITH	ERSBU	RG			MONT	GOM	ERY	
. Social Security Nu		6. Sex	7. Ag		ast birthday)	If Under 1 Year	If Under		8. Date of Bi	rth		9. Birt	hplace (State o	r Foreign
578-40-9	9322	1 □ M 2	<b>S</b> F	83	Yrs.	Months Days	Hours	Min.	July	17 1	925		untry) hingtor	D.C
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	10b. County			10c. City	Town or Loc								10d. Inside Ci	•
Md.	Mont	gomery			Galtin	ersburg							1 XYes	2 🗌 No
0e. Street and Num	ber					10f. Zip Code				10g. C	itizen of V	hat Co	untry?	
560 Rus	sell A	venue					208	77		U	nited	St	ates	
1. Marital Status			Decedent	Ever in U.S	3. 13. W	as Decedent of H Yes, specify Cub	lispanic Or	rigin? (Sp	ecify Yes or N	0-		e - Ame k, White	rican Indian,	
1 Never Marrie	ed 2 Marr	ied 1 🗆	Yes 2			☐ Yes 2 No	Specify		Thoun, oto.)			T.Tle	ite	
3 ☐ Widowed 4	4 Divorced	Yea	es, Give r or Dates:			165 2010	эреспу	•			Specify		.100	
(Special	15. Deceden	t's Education st grade comp	eted)		(Give k	ent's Usual Occup and of work done	during mos	st of work	ing	16b. l	Kind of Bu	siness/	Industry	
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12_	Fire 4 A Sid dla		4		поше	emaker	10 Moth	or's Nam	e (First, Middle					
17. Father's Name (#								elvn		nkno		e)		
Samuel	Blur	1t			1		Ev	етуп	. (01	סוואו	W11 )			
19a. Informant's Nar Hamilton			-	and		Address (Street Russell							Zip Code) 20877	
20a. Method of Dispo					ace of Dispos	sition (Name of atory or other pla	ce)		Date	20c. l	_ocation -	City or	Town, State	
1 ☐ Bunal 2 <b>/</b> 4 ☐ Donation			from State			tan Crem		12/	2/08	Al	exand	dria	, Va.	
21. Signature of Fur	neral Service	Licensee			22.	Name and Addre	ss of Facil	lity	Elean one -	l IIo	<b></b>			
mus	rief 8	1-13	erh	ev		Muriel H P. O. Bo			Lavton:			۸d.	20882	
23a. Part1. Enter th shock, or hear	e disease, or t failure. List	complications only one caus	that cause e on each l	d the death ine.	. Do not ente	r the mode of dyi	ng, such a	s cardiac	or respiratory	arrest,			Approximat Interval Bet	ween
Immediate Cause (F disease or condition	inal			er Fa									Onset and I	
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			Met	astat.	ic Car	cinoma							Months	5
Sequentially list con	ditions	D												

Physician /Medical Examiner

use as the burial-trai

attending physician for use as the buria

cate has been signed by the page 2 should be detached

certificate

this

After

filled in by the funeral director,

To the Hospital or Attending Physician:

hours after death.

within 24 hours after death To the Funeral Director:

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

**Physician** /Medical Examiner

**Funeral** Director

items 23a or 28a-f show

Director

Funeral

Completed by

Be ၉

Department of Health and Mental Hygiens are used to the Wall Will The Waryle Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Cervical Carcinoma

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 24a. Was an

2 No 3 Probably 4 X Unknown

Months

autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 X Natural

29a. Certifier

2 Accident

(Check only

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D 0017368 29d. Date signed (Month, Day, Year) December 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

0

2101 Medical Park Dr., #200, Silver Spring, Md. 20902 M.D. Schwartz, Stanley A. 31. Date filed (Month Day, Year)

State Registrar

32 Registrar's Signature



## Amend #17,20b-c, perFH G886 12/31/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland				Mental Hyg	iene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of l	Death	2. Date of Deat	eg. No.	008	3. Time of Death
	Physicia			roud.				November	Day	Year	10:40 A <sup>M</sup>
	/Medic		Geneva Shorter How 4a. Facility Name (If not institution, give s.			4b. City, Town, or	Location of Death			ty of Death	10.40 A
	Examin	eı	Springvale Terrace			Silver	Spring		Montgomery		
F	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign try)
D	irector		578-62-3320	M 2⊠F 96	Yrs.			Oct.26,	1912		ington,DC
and	W	1	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation	-			1	0d. Inside City Limits
Maryl	f sho	5	MD Montgomen	ry Sil	lver S	pring					X∏Yes 2 No
the	r 28a- notif	rec	10e. Street and Number			10f. Zip Code		11	0g. Citizen of	What Coun	try?
ר with	3a or	O E	8505 Springvale Ro	oad		20910			USA		
<b>5-0036</b> 72 hours after death with the Maryland	or rygients and artical solution and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2荃 No If Yes, Give		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		ace - Americack, White,	etc.
003	ural", Il Exa	d by	3 Widowed 4 □ Divorced	Year or Dates:	16a Dagge	dant'a Hausi Gasun	ation		16b. Kind of I	ьта	
2 2	"nat edica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	TOD. KING OF	business/inc	usuy
within	than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Prin	cipal			Educat	ion	
	other vent, th	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	Maiden Surna	ime)	
aryland	rked tic ev	To B	Charles F. Shorter				Jessie	Addison			
	and menta is marked aumatic ev	. [	19a. Informant's Name/Relationship (Typ			ng Address (Street					*
	12.5		Tracy DuPree Davi								y1and 20866
Baltimore,	Important: If Item 3 any In ury or other once.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State Nati		sition (Name of matory or other place Harmony M OLD			20c. Location andove rentwo	r, <del>od</del> ,Ma	ryland
Balt permit.	Import any In		21. Signature of Vineral Service License	herpson	7	2. Name and Addre	gia Avenu	e,NW Was	hingto		
i e			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the death re cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	ysician	i	Immediate Cause (Final disease or condition resulting in death)	Cancer of S	Small	Bowe1					
	Medical aminer		resulting in death)	Due to (or as a consequ	ence of):						
		,	Sequentially list conditions,		ence of):					_	
D 3	nsit	Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury							-	
exect	in and ial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):						
8760, cate be exe	ohysician and the burial-transit	dical	d								
riffical	as th	Medi	IE ECNANI C.						1		
Records, P.O. Box 68760, The law requires that the death certificate be executed	attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnate 1 ☐ Live birth 2 ☐ Fetal	death 3[	⊒Ectopic pregnancy	y			ate of delive	ery Day Year
G G G	by the at stached fo	sici	1 ☐ Yes 2X No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify) _				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ouy rou
P.O	d by setacl	P.	Part il. Other significant conditions con	ntributing to death but not resu	ttina in the u	nderlying cause giv	ren in Part i.	23e. Did tot	bacco use co	ntribute to th	ne cause of death?
ds,	signed I	l by	Dehydration, Anem		3	, 0		1 🗆 Ye	es 2 No	3 ☐ Prob	ably 4- Unknown
O v	should	etec	2011, 420-2011, 111-011					24a. Was a	n 24h	Were auto	ney findings available
Records, The law requires t	has e 2	Completed						autops	med?	death?	psy findings available mpletion of cause of
	rtificate stor, pag	မ င်	25. Was case referred to medical				26 Place of Dea	1 Yes :	2 <b>X</b> No	1 ☐ Yes	2∐No
or Vita Physiclan:	is certific director,	To Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier	nt 3 DOA Oth	or:	lome 5 Reside		ther (Specif	iv)
	<del>=</del> ₩		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury			28d. Describe ho			
vision (	arn. or: After ne funei	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day Year)	injury		Yes 2 □ No				
- 0 t	s arrer dearn.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (Si City or Town	treet and Nun n, State)	nber or Rura	il Route Number,
I 5	within 24 hours at <b>To the Funeral C</b> completely filled i	edical (		ner: On the best of my knowner: On the basis of examinat and manner stated.							
To the	within 2  To the comple	Me	29b. Signature and title of certifier	11 9	10/	29c. Licens	se number	2	9d. Date sigr	ned (Month,	Day, Year)
10	)		) Vou	evi 1	UNI	N D0339	16	1	Decemb	er 2,	2008
,			30. Name and address of person who co								
			Dr. Robert Dibble	110 Irving S 32 Registrar's Signat	treet	, NW Wash	ington,	DC 20010			
	Sta Regist		31. Date filed (Month, Day, Year) <b>DEC 0 5</b> 200	1 49		acti s					

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State of Maryland / Depart	ificate of Death	, ,	. No. 2008 1,	730
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time	of Death
	/Medic		LEMUEL ATHELSTAN HENRY			2008 12:4	40 A <sup>M</sup>
and.	Examin	er	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER	b. City, Town, or Location of Death $f BETHESDA$	n	4c. County of Death MONTGOMERY	
	Funeral		157.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(State Country)	or Foreign
	Director		Usual Residence of Decedent			1964 JAMAIC	
	/land		10a. State 10b. County 10c. City, Town or Locat	tion		10d. Inside	City Limits
	Mary a-f sh	ţċ	MD. PRINCE GEORGES LA	ANDOVER HILLS		1 ☐Ye	s 2 No
	th the or 28	Director		10f. Zip Code	10g	. Citizen of What Country?	
	ath wi		3709 POGONIA CT.	20784		U.S.A.	
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	s Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>	
36	irs aft	by F	1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □XNever Married 2 □ Married   1 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2 □ XNever Married 2	Yes 2 No Specify:		Specify: BLACK	
ŏ	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Eventher must be notified at	ted	15. Decedent's Education 16a. Deceden	nt's Usual Occupation	. 16	b. Kind of Business/Industry	
21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evandrat must be notified at	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) life. DO	nd of work done during most of world NOT use retired)	king		
121	led will have the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her the her	Col		J.S. NAVY	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	DEFENSE	
Maryland	ld be fi lental F ked ot ic evel	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma		
ΣŽ	should be and Mental s marked o umatic ev	L <sub>0</sub>	AUSTIN HENRY  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing A	Address (Street and Number or Ru	YVONNE	CLARKE	
Ž	d 2 th a tra			ARFIELD AVE., BR			
ore	es 1 s of He fitem r oth		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State	
Baltimore,	Pag tment tant; I			JETERANS CEM. 12	-12-2008	CHELTENHAM, MD	•
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		CHA	lame and Address of Facility AMBERS FUNERAL HI D1 CLEVELAND AVE	OME & CRE	MATORIUM, P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.			, Approxima	ate etween
	Physician		Immediate Cause (Final disease or condition resulting in death) a. ACQUIRED IMMUNE	DEFICIENCY SYNI	DROME	Onset and	Death
*	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
B	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C,				
0,	e exe sian al urial-t	EX	resulting in death) Last  Due to (or as a consequence of):				
68760,	rtificate be executed ng physician and as the burial-transit	Medical	d				
×	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
. Box	death e atte d for i	Physician/	in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ed 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ O	ctopic pregnancy hther (specify)		Month Day	Year
P.O.	at the	hys	9 ☐ Unknown				
Vital Records,	uires th signed d be de	ğ	Part II. Other significant conditions contributing to death but not resulting in the unde	rlying cause given in Part I.		co use contribute to the cause of  2 ☑ No 3 ☐ Probably 4 ☐	
COL	w req	lete			24a. Was an	24b. Were autopsy findings	
Be	The la	Completed			autopsy performed	prior to completion of death?	cause of
ita	stan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 □ Yes 2 by th <i>(Check</i> o <i>nly</i> o <i>ne)</i>	No 1 □ Yes 2 □ No	
× ×	hysic this ce al dire	၉	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: 4 □ Nursing Ho	ome 5 🗆 Residenc	e 6 □Other (Specify)	
ü	Jing F	io iii	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
Division of	Attend death sctor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	M 1 Yes 2 No	28f. Location (Stree	t and Number or Rural Route Nu	mher
2	ital or / irs after ral Dire	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		City or Town, S	tate)	niber,
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. Within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or invessand manner stated.	ccurred at the time, date and place stigation, in my opinion, death occur	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(	s)
		Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
	341		The formation	01055104A (IN)	) L	RC, 2, 2008	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	MATTONAL NAV			
	Sta	e	MICHAEL R. BAYDARIAN LCDR MC USN  31. Date filed (Month, Day, Year)  DEC 0 5 2008  Registrar's Signature	BETHESDA MD	∠U089-36U	IU.	
	Registra	ar.	DEC 0 5 2008	5 A			

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State of Ma	aryianu /	-	rtificate of L			ieniai my	gierie Reg. No.	711	08	40308
H	Physicia	an		ne (First, Middle, La	st)						2. Date of Do Month	eath Day	, `	Year	3. Time of Death
	/Medic	al	4a Facility Name /		Rudolph Scott	Handel		4b. City, Town, or	Location	of Doath	Decem		2008 County o		9:15 am <sup>™</sup>
Ĵ	Examin	er	17025 Oak		e street and number)			Spencerv		or Death			ontgom		
	Funeral		5. Social Security N	Number 6. 8		e (In yrs. last t	oirthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth			lace (State or Foreign
	Director		100-56-	/496	I <b>X</b> M 2 □ F	44	Yrs.	Wichins Buys	riouis		November	30,19	964		ew York
	and		Usual Residence o	10b. County		10c. City, To	wn or Loc	cation						10	Od. Inside City Limits
	Maryl -f sho	tor	Maryland	Montgo	merv			Spend	cervil	1e					1 □Yes 2 No
	h the	Director	10e. Street and Nu					10f. Zip Code				10g. Citi	zen of Wh	at Coun	try?
	th with	a la	17025 Oak	Hill Road					2086	8				U.S.	.A.
	tems	Funeral	11. Marital Status		12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Or n, Mexicai	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-	<ol> <li>Race Black,</li> </ol>	Americ White, e	
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, It a feetical Examination and the routified a	by F	1 ☐ Never Mari	ried 2 Married 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates;	10	1	□Yes 2⊠No	Specify:	:			Specify:	τ	White
Maryland 21215-0036	2 hou	ted	(0	15. Decedent's E	ducation	16	a. Deced	lent's Usual Occupa kind of work done d	ation	at of worki		16b. Ki	nd of Busi		
2	thin 7 ne. nan "n	Completed	Elementary/Sec	cify only highest gra ondary (0-12)	College (1-4or 5	+)	life. E	OO NOT use retired,	anng mos )	it of works	ng				
2	led wi tygier her th	ဝိ	47 F.W. J. N.	(First Middle Leas	5+			СРА	10 Math	ar'a Nama	(First, Middle	Moldon			oloyed
anc	W (0) -	Be		(First, Middle, Last					16. MOUTE		nda Maur		,		
2	should nd Me mark matic	၉		lph Charles  Iame/Relationship		19	9b. Mailin	g Address (Street a	and Numb						Code)
≥	es 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic			erly M. Han				Oak Hill Re				-		-	,
e,	of He		20a. Method of Dis	sposition				sition (Name of natory or other place			ate		cation - C		wn, State
Ĕ	t. Pages 1 and 2 tment of Health tant: If item 27 I jury or other tre			5 Other (Speci	Removal from State	Norbe	ck Mer	norial Park	5 1 6	12/07	/2008	01ne	e <b>y, M</b> a	rylar	nd
Baltimore,	permit. Pag Department Important: I any Injury c once.		21. Signature of F	uneral Service Lice	nace de la la	×4.	Н	. Name and Addres lines-Rinald 1800 New Ha	li Fun	eral l	Home, In	c. Iver S	Inrino	MD	20904
			23a. Fart 1. Enter	the disease, or com	plications that caused	the death. De			•				Pring	,	Approximate Interval Between
1	Physician		Immedi use disease or conditi	(Final	one cause on each lir	nant Glio	om a								Onset and Death  10 months
	/Medical		resulting in death)	•	W	a consequence									TO MONEILS
	Examiner	<u>.</u>	Sequentially list co	onditions,	b		0.							_	
B	ted nsit	nine	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease of that initiated event	nmediate ertying r injury	Due to (or as	a consequence	e or):								
,	execunand and ial-tra	Examiner	that initiated event resulting in death)	s Last	c Due to (or as	a consequence	e of):								
8/60,	tificate be executed g physician and as the burial-transit	edical			<b>_</b> d										
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Ř	death certific e attending p d for use as i	Physician/N	23b. Was deceder		23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy	,			2	23d. Date Mont		ry Day Year
	the de	ysic	1 □ Yes 2 9 □ Unknowr		4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5∟	Other (specify)	·						,
т.	law requires that the de as been signed by the 2 should be detached	P P	Part II. Other signi	ficant conditions	contributing to death be	ut not resulting	in the un	nderlying cause give	n in Part I	l.	23e. Did	tobacco u	se contrib	ute to th	e cause of death?
g	requires seen sign hould be	ed by									1 🗆	Yes 2	<b>∑</b> No 3	☐ Prob	ably 4 ☐ Unknown
Hecords,	e law re has bee	plet									24a. Was		24b. We	ere autop	osy findings available inpletion of cause of
_	The late has page	Completed									perf 1 □ Yes	ormed?	de	ath? ⊒Yes	
/Ital	ding Physician: The intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitation of the intermitat	Be	25. Was case refe examiner?	rred to medical	Linesiteli			Louis			(Check only	one)			
0	Physical dire	<u>۹</u>	1 ☐ Yes 2 2 27. Manner of Dea		Hospital: 1 ☐ Inpatie 28a. Date of Inju	nt 2 ER/0	Outpatien Time of		4 L N		me 5 ARes 28d. Describe				)
0	ding h. After funer	tion	1 X Natural 2 Accident	5 Pending investigatio	(Month, Day	y, Year)	Injury	Work	? ′es 2□		zou. Describe	now injury	y occurred	,	
DIVISION	Atter	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not b		ury - At home,	farm, stre	eet, factory, office			28f. Location	Street and	d Number	or Rura	l Route Number,
בֿ	Ital or rs afte al Dir led in	Certification:	4 🗀 i lolliicide		building, ex	, (Opecny)				l l	City of To	wii, State,	<i></i>		
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	edical	29a. Certifier (Check only one)		h <b>ysician:</b> To the best ominer: On the basis of and manner sta	f examination :									
	Vithi Vott	Me	29b. Signature and	title of certifier	0/1/1/	/		29c, License			0	29d. Dat	e signed (	Month, I	Day, Year)
	12		P (/a	usun	Brauce	> M	ρ	000	06	109	7	Dece	mber 3	, 200	08
			/		completed cause of				1M17	D-1	rimo	Max1 -	and Or	221	
	Sta	te_	31. Date filed (Mor	nth, Day, Year)	akeley, M.D.				= TMT6	, Dal	crmore,	riary18	and ZI	23L	
	Registr		I	DEC 0 5 2	008	ar's Signature	30								

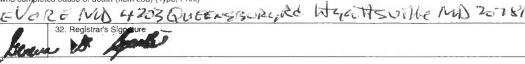
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Eileen 4:50A M В. Jurawan 2008 Dec 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Thomas More Nursing Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□ M 2🛛 F 062-28-4279 90 June 14,1918 Director Barbados Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho ¶Yes 2 □ No Director Maryland Prince Georges New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6209 86th Ave, 20784 Barbados Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify: White 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 l (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygie
Important: If item 27 is marked other ti
any Injury or other traumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Colridge G. Shorey Marie Al-Fagoi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Jurawan (SOII)6209 86th Ave. New Carrollton, MD 20784 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | Dec. 8,2008 Beltsville, Maryland 22. Name and Address of Facility 21. Signatur Funeral Service Licensee Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. P. 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cruse on each line. mmediate Cause (Final disease or condition resulting in death) **Physician** NOCONCINONA Calls /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page 2 1 ☐ Yes Il or Attending Physician: after death. Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

er 5

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 8 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-6-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:257 December 5, 2008 Physician Kesterson В. Gladys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ft. Washington Health & Rehab Ctr. Prince George's Ft. Washington 8. Date of Birth (Month, Day, Sept. 30, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min. 1 ☐ M 2**XX**F 230-10-9607 91 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If I well and I was a specific to the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the stand 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15417 Bealle Hill Road 20607 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2XX No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo Specify Specify: ¾X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Sears Roebuck & Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W. Peacher Daisy Be11 McClary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15417 Bealle Hill Rd., Accokeek, MD 20607 Joyce W. Taylor / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 12/10/2008 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License George P. Kalas Funeral Home PA Kely 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part / Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (andis Van **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2XXNo Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4XX Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
DEC 0 8 2008



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 2, 2008 **Physician** 10:00 A M Anna B. Kidd /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4401 Upper Beckleysville Road Carroll County Hampstead If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 21, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 XF 013-03-7664 90 1918 Mass. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show or items 23a or 28a-f shor miner must be notified at Maryland Carroll County Hampstead 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Examiner must be 4401 Upper Beckleysville Road 21074 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2K No Specify. þ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If then 27 is marked other than "n any injury or other traumatic Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Purvis John Berry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Romaine Cape - daughter 4401 Upper Beckleysville Road, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 8, Hampstead Cemetery Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility of Funeral Service Licens Fline Funeral Home Hampstead, Maryland 21074 934 South Main Street M01072 luns Approximate Interval Between Qnset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** 0(40 disease or condition resulting in death) /Medical Due to (r as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed burial-transit enti 250 that initiated events and resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ptributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has autops) perform 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 🗀 Yes 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident Injury 5 Pending 1 TYes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, To the Hospital or Attending Pt.
within 24 hours after death.
> To the Funeral Director: After it completely filled in by the funeral WJL 4

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

State Registrar

Medical

31. Date filed (Month, Day, Year) DEC 0 5

29a. Certifier

(Check only one)

29b. Signature and title of certifier

5MG

KIShre

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 32. Registrar's Signature

ger stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

8

29d. Date signed (Month, Day, Year)

21134

### Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

		-	1 - For State Registrar	State of Marylar		artmen rtificat			nd Me		giene (	08 40812	)
	Physici: /Medic	an	1. Decedent's Name (First, Middle, Last)  Anna Kcl	ta					2	Date of Dea Month	Day 29	Year 2008 1047 PM	
ı	Examin		4a. Facility Name (II not institution, give s	street and number)		4b. City,	Town, or	Location of	Death		4c. County of		
	Funeral Director		5. Social Security Number 6. Sep	7. Age (In yrs.	last birthday) 86 Yrs.	If Under Months	1 Year Days	If Under 2	Min. J	Date of Birt (Month, Day AN . 25	h	9. Birthplace (State or Foreign Country) Maryland	
	aryland show		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation Airy	7					10d. Inside City Limits 1	
	the Market	recto	Maryland Carroll  10e. Street and Number		Modife	10f. Zip					10g. Citizen of W		_
	23e olust be	ralD	716 Merry Go Rou	nd Way			1771		_		United		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event, it is Medical Examinant must be medical and once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in UArmed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Dece if Yes, spe	cify Cubai	spanic Orig n, Mexican, Specify:	in? (Specit , Puerto Ric	fy Yes or No- can, etc.)		- American Indian, k, White, etc. : White	
21215-0036	vithin 72 hounde. Then "nature of Wedical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	life.	dent's Usu kind of wo DO NOT u	ork done d se retired,	uring most	of working		16b. Kind of Bus		
	ild be filed v lental Hygie ked other t Ic event, ID	To Be Co	17. Father's Name (First, Middle, Last)  James L. Sc	hultz	Hon	ilelliak (		18. Mother			Maiden Sumame Baugher		
Maryland	nd 2 shoulth and M 27 is mai	jan.	19a. Informant's Name/Relationship (Ty Joan Yednock /dau								or, City or Town, S Maryland		
ore,	ges 1 au t of Hea if item or othe		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ F		Place of Dispo cemetery, crea	osition (Na matory or	me of other place		Dat			City or Town, State	_
Baltimore,	permit. Pa Departmen Important: any injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		rklawn 2	2. Name a	nd Addres	s of Facility	2/04/ ′Sta	uffer	Funeral	le,Maryland Home	
	20 E 2 3		23a, Part1, Enter the disease, or compl	electory ications that caused the dea								Approximate	
	Pnysician		shock or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.				Drs	-			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse									
	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar I Indamping. Cause (Disease or injury that initiated events.	Due to (or as a conse	quence of):								
3760,	ate be executed hysician and the burial-transit	Ical Exar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
9	entifical ding physe as th		IF FEMALE:	23c. If yes, outcome of pregn	2007						and David		_
.O. Box	that the death certificated by the attending placed for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[	□Ectopic p □ Other (s					Mon	e of delivery hth Day Year	
s, D	igr be	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying	cause give	on in Part I.				ibute to the cause of death?  3 Probably 4 Gonknown	
Record	e law has b je 2 s	ompleted								24a. Was autop perfo	rmed? p	Vere autopsy findings available rior to completion of cause of eath?	
Vital	Physicien: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	Hospital:			Othe		/	Check only o			
o	Phys r this ral dii	lon: To	27. Manner Death  1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	41_71401	28		dence 6 Othe		_
Division	or Atten ifter deal Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st					f. Location (S City or Tox		ar or Rural Route Number,	
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	ledical C		sician: To the best of my kn iner: On the basis of examin and manner stated.									
	To the within 2 To the comple	Me	29b. Signature and title of certifier				c. License				_	(Month, Day, Year)	
	5		I / Idigle		wo	×	900	5942	-3		Deemlo	er 1 2008	
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	Print)	Circl	le In.	te A	150-23	36 Clark	er 1 2008	9
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Spo	Me.		,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Z: 20 PM OELLEIN NOVEMBER 30, 2608 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** BALTIMORE MARYLAND UNIVERSIT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ₹M 2 □ F 82 219-18-8549 Maryland April 02,1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Expansion munt by modified at 1 ☐ Yes 2√2 No Anne Arundel Severna Park MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Severna Park 604 McKinsey Park Drive, Unit 105 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after XYes 2□No WWII Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 TyNo Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired Commissioner of College (1-4or 5+) is marked other than Elementary/Secondary (0-12) State of Maryland Department of Labor & Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H fitem 27 is marked oth Molly Pasterfield Henry Koellein, Sr. 19b. Mailing Address (Street and Number or Byral, Route, Number, City or Town, State, Zip Code)
604 McKinsey Park Drive Severna Park, MD 2 19a. Informant's Name/Relationship (Type. Print) 21146 Barbara A. Koellein/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Pages 1 20a Method of Disposition Dec 2008, Department of Important; If it any Injury or c Glen Haven Memorial Park 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Signature of Funeral Service Licensee 23a. Pai 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCHROIAL INFARCTION Physician AWTE resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit RENM AWTE Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 MNo 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed

24 hours after deatle Funeral Director: completely within 2

filled in by the

State Registrar

Medical

29c. License number 29d. Date signed (Month, Day, Year) AU4176435 P18986 NOVEMBER 30, 2008 MO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE ST, BALTIMORE, MO 21201

TIMOTHY 31. Date filed (Month, Day, Year) DEC 0 4 2008

29b. Signature and title of certifier

29a. Certifier

. Registrar's Signature

1 💟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Funeral Director

Physic /Medi Exami

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> Sta Regist

	For State Registrar	Certifica	te of Dea	th	F	Reg. No. 2001	8 40814
an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th 2508 Year	3. Time of Death
cal	Dolores Ruth Kapp	Ah Cib	. Town or I cost		NOV 25,		11:45 AM
ier	4a. Facility Name (If not institution, give street and number)  Future Care Pineview Home	1 '	, Town, or Locati inton	on of Death		4c. County of De	
	5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Unde	er 1 Year   If Un	der 24 Hrs.	8. Date of Birth	n 9. B	irthplace (State or Foreign
	271 26 9058 1□M 2\mathbb{R}F 79	Yrs. Months	Days Hou		(Month, Day Feb 17.		Country)
	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location					10d. Inside City Limits
ō		ttsville					1 ☐ Yes 2 No
rect	10e. Street and Number		ip Code			10g. Citizen of What C	country?
Funeral Director	4924 Donovan Place		20781			Unite	ed States
ner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Deci	edent of Hispanic ecify Cuban, Mex	Origin? (Spe	cify Yes or No-	14. Race - Am Black, Wh	
y Fu	1 Never Married 1 Yes 2 Y No	1 □ Yes				Specify: W	•
Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Us				16b. Kind of Busines	
plet	15. Decedent's Education (Specify only highest grade completed)		ork done during r	most of workir	ng	TOD. KING OF BUSINESS	S/III dustry
mo	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker				Own Home	9
Be	17. Father's Name (First, Middle, Last)		18. M			Maiden Surname)	
7	Julius Jaeger			Maud	Navarr	·e	
	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,	
	Elaine Mohun (Daughter)  20a. Method of Disposition 20b. Pla				, Clint	on, MD 207	
	I I I Burial ZX.XCremation 3 Li Removal from State 1	ace of Disposition (Nametery, crematory or				,	
	4 Donation 5 Other (Specify)  21. Signature Futeral Society Insee	22. Name a	ory NOV and Address of Fa	i ZO, Z	Funeral	Clinton, M Home, Inc	laryland 6633 Old
	28 7846) MO1464		ndria Fe				20735
	23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	-					Approximate Interval Between
	Immediate Cause (Final	munary Fa:	ilure				Onset and Death
	resulting in death)  a. Due to (or as a conseque		12.41.0				
پ	Sequentially list conditions, if any, leading to immediate b. Alzheimer  Due to (or as a conseque	s Disease	, End St	age			
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):					5
xar	that initiated events c	ence of):				-	
call	<b>L</b> d						
Medical Examiner	IS SEAMLE.						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal		pregnancy			23d. Date of d Month	elivery Day Year
Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 5 Other (	specify)			WOTH	Day Tear
Phy	Part II. Other significant conditions contributing to death but not resul	ting in the underlying	cause given in Pa	art I.	23e. Did to	bacco use contribute	to the cause of death?
Completed by					1 □ Y	es 2 No 3 I	Probably 4 \ Unknown
lete			-		24a. Was a	an 24b. Were a	autopsy findings available
duc					autop: perfor	sy prior to med? death?	completion of cause of
Be C	25. Was case referred to medical		26. P	lace of Death	1 Yes (Check only or	2 X No 1 □ Ye ne)	es 2 No
ල ස	examiner? 1 ☐ Yes 2 🖫 No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 🗆 🛭	Other:			ence 6 Other (Sp	ecify)
L:uo	27. Manner of Death 1 A Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	2	28d. Describe h	ow injury occurred	
cati	2 Accident investigation	М	1 ☐ Yes 2				
ıtifi	3 ☐ Suicide determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, street, facto )	ry, office	2	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
S E	29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death occurre	d at the time, dat	e and place.	and due to the	cause(s) and manner	as stated.
Medical Certification: To	(Check only one) 2 Medical Examiner. On the basis of examinati and manner stated.	on and/or investigation	on, in my opinion,	death occurr	ed at the time, o	date and place, and do	ue to the cause(s)
Me	29b. Signature and title of certifier	2	9c. License numb	er	2	29d. Date signed (Mor	nth, Day, Year)
	Muse		D_51520	O		Nov 28,20	008
	30. Name and address of person who completed cause of death (Item					_	
	Bahram Pishdad, MD 1328 Souther 31. Date filed (Month, Day, Year) 32. Registrar's Signati	n Ave S.E.	Suite 3	10, Was	shingto	n, DC 2003	2
ite ar	Bahram Pishdad, MD 1328 Southers 31. Date filed (Month, Day, Year)  DEC 0 5 2008	& Spart					

### 08-088<mark>95</mark> Michele Thornton

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of	Maryland / Depa	rtment of Hea	aith and Mental H	ygichic
Otato of	Titles y			

			r State		Certific	cate of	Death			Reg. No.		3. Time of Death
Physicia ' Examii	an/	Regi 1. D	ecedent's Name (First, Midd		hornton Kunze					Day er 26, 2008	Year nty of Dear	2004 hrs
		4a.	Facility Name (if not institution	on, give street and	number)	41	b. City, Town, or White Plain			Char	les .	021. II. E
Funeral			ocial Security Number	6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Day		lin.	3/1959	Fore	irthplace (State or ign country) Virginia
irector			231-86-1432	1 M 2 X	F 49	Yrs.			01/10	7/ 1/3/		
V = 3.			al Residence of Decedent State 10b. County	1	10c. City, Tov	vn or Location	on					10d. Inside City Limits
w any							Ro	ckville				1 Yes 2 X No
/kand -f shc once	tor	M.	aryland Mor	ntgomery			10f. Zip Code			10g. Citizen	of What Co	ountry?
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygoria. The tean 21 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner.	Director	100		. D				20852				S.A
th the 23a o notifi	a D		4800 To	opping Road	Decedent Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin? (	Specify Yes or I		Race - Am White, etc.	erican Indian, Black,
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Funeral	1	Never Married 2 X	marrieu [	ed Forces?	l l	es, specify Cuba		sto Ricari, ctc.,			
ter de	ΙŒ	1 .3	Widowed 4	Divorced If Yes, Give	e Year		Yes 2 X N				of Pusines	White ss/Industry
d be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	À	î	5. Decedent's Education (Sp	pecify only highest	grade completed) 16	Sa. Deceder	nt's Usual Occupa nost of working lif	ation (Give kind e. DO NOT use	of work done retired)	Top. Kind	OI DUSINES	ss/iliddsti y
72 hou n "na al Exx	Completed		Elementary/Secondary (0-12	2) Colle	ge (1-4 or 5+)	<b>22</b> g				- F	laatmi	cal Company
ne. r tha	1 2		12				Bookkee	eper 18 Mother's Na	ame (First, Middl	e, Maiden Sur	name)	car company
led w Hygie othe	3		. Father's Name (First, Midd						Margo		nown)	
uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	8		James Th	ornton	)	19b. Mailin	ng Address (Stre	eet and Number	or Rural Route I	Number, City of	or Town, St	ate, Zip Code)
shoule and M 7 is m	1	2   18	Brian T. Kun				Topping		kville, M	arvland	20852	
alth a		20	a Method of Disposition		20b. Pla	ace of Dispo	sition (Name of o	cemetery,	Date	20c. Loc	ation - City	or Town, State
es 1 a of Hit If it ther t		1	Burial 2 X Crema		val from State	,	n Cremator	-v	12/08/200	8 Bre	ntwood	, Maryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Mediniury events are supported to the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the event of the ev		- 4	Donation 5 Other  1. Signature of Funeral Serv	Specify:	Ft.	22.	Name and Addre	ess of Facility	Hines-Rin	aldi Fur	eral H	lome, Inc.
Depar Impo		2		A 1 ./	· (du -	1	1800 New	Hampshire	Avenue.	Silver S	pring,	MD 20904
nysiciar	_	2	3a. Part I. Enter the disease	, or complications	that caused the death. I	o not enter	the mode of dyir	ng, such as card	ac or respiratory	arrest, shock	, or heart	Approximate Inter Between Onset a
ledica			failure List only one can	use on each line.	e Injuries			- R				Death
∡amine	r	C	r condition resulting in deat		or as a consequence of):							
		,	sequentially list conditions,	b								
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		Ē I /	Disease or injury that initiate events resulting in death) La	ed C.	or as a consequence of)	:						
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exec	lal .	ledical	UNPENDED	AMEN	IDED					224	Date of de	livery
icate be executed physician and	ne bui		F FEMALE:		If yes, outcome of pregn	ancy	Fetal death	3 Ectopic p	regnancy		Month	Day Year
death certific	e as th		3b. Was decedent pregnant past 12 months?	1 4	Live birth Pregnant at time of dea		Other (Specify)					
leath certific	for us		1 Yes 2 No 9 🗸		Unknown							ite to the cause of death?
the de	ched	影	Part II. Other significant co	onditions contrib	uting to death but not re	sulting in th	e underlying cau	se given in Part				Probably 4 Unknow
s that t		b o								Was an		ere autopsy findings avail
law requires that	onld	Completed								autopsy	pric	or to completion of cause ath?
law r has b	2 sh	힐								performed? Yes 2 No		Yes 2 No
cian: The	, pag	Š.	25. Was case referred to me	edical			26.F	Place of Death (C	Check only one)			
ician	recto	m۵	examiner?	Hospital	1 Inpatient 2	ER/Outpati	ient 3 DOA	Other <sub>4</sub>	Nursing Home			Other: Scene
Phys Phys er thi	eral di	e.	1 ✓ Yes 2 No 27. Manner of Death	28	a. Date of Injury	28b. Time	1 1	Injury at Work?	Subject	cribe how inju t pushed in	ry occurred ito traffic	
ding Ph	e fune	ē	1 Natural 5	Pending	(Month, Day, Year) lov 26, 2008	2000 hrs		Yes 2 🗸 I	NO I			
<b>=</b> # 45 %	by th	Certification:	2 Accident	Could not be	Be. Place of Injury - At h	ome, farm, s	street, factory, off	ice building, etc				or Rural Route Number,
Attend Attend rector:	= 1	ŧΙ	3 Suicide 6 Suicide	determined (	Specify) Major Roa	d / Highw	vay					en Boulevard, White I
DIVISIOI tal or Attent rs after death al Director:	ed	<u>a</u> 1	4 Momicide  4 Momicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my control of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause						ce, and due to th	e cause(s) an	d manner a ce, and du	as stated. lie to the cause(s)
UNISION  Tospital or Attent 4 hours after death Tuneral Director:	ely filled in by the funeral director, page	Cel	29a. Certifier 1 Certify	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the time, date and place, and the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition of my knowledge, death occurred at the composition occurred at the composition occurred at the composition occurred at the composition occurred at the composition occurred at the composition occurred at the composition occurred at the composition occurred at the composition occu						red at the time, date and place, and due to the cause(s)		
DIVISIOI the Hospital or Attent thin 24 hours after death the Funeral Director:	mpletely filled i	dical Cer	29a. Certifier 1 Certify (Check only one) 2 Medica	I Examiner: On th	e basis of examination a nanner stated.				29c. License number			d (Month. Dav. Year)
DIVISION Of VITAI RECORDS, F.O. BOX 901 901  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled i	Medical Cer	29a. Certifier 1 Certify (Check only one) 2 Medica	al Examiner: On th and r	e basis of examination a	,	29c. L	icense number		29d. I	Date signe	d (Month, Day, Year)
Division of Vital Records, to the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s	completely filled i	Medical Cer	one) 2 • Medica	al Examiner: On th and r	e basis of examination a	<i></i>	29c. L			29d. I	Date signe	d (Month, Day, Year) 27, 2008
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Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	completely filled i	Medical Cer	one) 2 Medica 29b. Signature and title of o	al Examiner: On the and recertifier	e basis of examination a	n 23a) er 111	29c. L	o.C.M.E.		29d. I	Date signe	d (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

			Please	Type or Prin							•	
		1 - For State Registrar		State of Ma	ar yıarı		artment of F rtificate of			Reg. No.	200	8 40316
Physicia /Medic		1. Decedent's Name Rufino	e (First, Middle, Las G .	t) Lustan					2. Date of Dea		, 2008 <sup>ar</sup>	3. Time of Death 9:26 P M
Examin		4a. Facility Name (I	f not institution, give	street and number)			4b. City, Town, o	r Location of Death	า		County of Dea	
			Maryland				Clinto				ince Ge	
Funeral Director		5. Social Security N 586–60–27	717	ex 7. Age	e (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April	Year)	929 Phi	rthplace (State or Foreign ountry) Tippines
w w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation	<u>-</u>				10d. Inside City Limits
/laryla	ō	Maryland	· .	George's		on Hil						1 □ Yes 2 No
the N	Director	10e. Street and Nur		ocorge B	O A	011 1111	10f. Zip Code			10g. Citi	zen of What C	ountry?
3a or		1026 Bro	oderick Di	rive			20745	5		USA	A	
death	Funeral	11. Marital Status		12. Was Decedent I	Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S	pecify Yes or No	.	14. Race - Am Black, Whit	
after or ite			ied 🗷 Married	1xXYes 2 □ N	195. 7		1 ☐ Yes 2 No	Specify:	o riidan, cic.)		Specify: Fi	,
nours ural",	d by	3 Widowed		Year or Dates:			death Hend Occur	- ation		105 10	nd of Business	
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al Hyg othe vent,	Be C	17. Father's Name	(First, Middle, Last)		_			18. Mother's Nan		Maiden	ŕ	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	To E	Joaquin		Lustan	L			Basili	sa		Losa	ria
2 sho			ame/Relationship (7				ng Address (Street					Zip Code)
t and Health		Anita S.	. Lustan –	- Wife	20h E		Broderick	<u>·</u>	On Hill		20745 cation - City or	Town State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be profifted at once.		1 <mark>X</mark> ⊡ Burial 2 [	□ Cremation 3 □				osition (Name of matory or other place National					
artme artme ortani injury			5 ☐ Other (Specify Ineral Service/Licen		ALL			'				, vA
permi Depa Impo any it		the	1. July			6	2. Name and Addre George P. 160 Oxon	Kalas Fu Hill Rd.	neral Ho . Oxon H	ome, Hill	P.A. . MD 20	745
		23a. Part 1 Enter the	he disease, or comp	olications that caused	the deat						,	Approximate Interval Between
Physician		Immediate Cause (	(Final		nte	Myo	cardeal	In Fure	tion			Onset and Death
/Medical		resulting in death)		Due to (or as	a conseq	uence 6t).						
Examiner	_	Sequentially list cor	nditions,	b								
ted nsit	nine	Sequentially list confidence if any, leading to implement cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a conseq	uence or):						
be executed sician and burial-transit	Examiner	that initiated events resulting in death) I	Last	Due to (or as	a conseq	uence of):						
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eath cerl attendin for use a	an/	23b. Was decedent in the past 12	t pregnant	23c. If yes, outcome 1 ☐ Live birth	2 Feta	Ideath 3[	☐ Ectopic pregnanc	y		2	23d. Date of de Month	livery Day Year
ne deg the an	/sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of o	leath 5	Other (specify)				WOTH	Day 16ai
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical C	29a. Certifier (Check only one)		ysician: To the best on the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the bas	f examina							
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Qii			Shha	Mo			300 55	120		12-	4-2008	
0		30. Name and addr	ess of person who o	completed cause of d		4	Print)					
		Richard Par		1328 Sout	ham	ave so	E Suite 310	2 Washing	bade 2	W 37	2	
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, roi	partment of Health and Mental Hygiene  ertificate of Death  Reg. No. 2 1 1 2 4 1	01
	Physici		1.Decedent's Name (First, Middle, Last) Oliver K. Larison	2. Date of Death 3. Time of	of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton  4c. County of Death Prince George's	
	Funeral Director		5. Social Security Number  577-28-5090  Usual Residence of Decedent  6. Sex 1 ☑ M 2 ☐ F  7. Age (In yrs. last birthday 92 Yrs.	Months   Days   Hours   Min   To (Month, Day, Year)   1 A = Country   T	or Foreign Sey
	e Maryland la-f show	ctor	10a. State 10b. County 10c. City, Town or L Maryland Prince George's 0xon Hil		City Limits
	23a or 28	ral Dire	10e. Street and Number 6927 Elkins Ave.	10f. Zip Code 10g. Citizen of What Country?  20745 USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Modicul Examic or must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	within 72 ho iene. than "natui re Medicel	Completed	(Specify only highest grade completed) (Giv	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired)  Tronic Technician  16b. Kind of Business/Industry Federal Government	
Maryland 2	uld be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Emily H. Larison	18. Mother's Name (First, Middle, Maiden Surname) Helen Kugler	
	and 2 sho salth and n 27 is ma		1 1 21	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Elkins Avenue Oxon Hill, Maryland 20745	
Baltimore,	Pages 1 ment of Ha ant: If iten ury or oth		4 Donation 5 Other (Specify) Kalas Cre		
Balt	permit. Depart Import any Inj		Jo F. Jales 1	22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745	
	Physician /Medical Examiner		23a. Part 1. Enter the discase, or complications that caused the death. Do not enshow, or heart failure. List only one cause on early fine.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or is a consequence of):	enter the mode of dying, such as cardiac or respiratory arrest, Approximat Interval Bet Optset and Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of t	tween
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Division	To the Hospital or Attending Physician: The within 24 but a fire death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)	nber,
	e Hospi 1 24 hour e Funer letely fill	Medical		eath occurred at the time, date and place, and due to the cause(s) and manner as stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s	s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c, License number 29d. Date signed (Month, Day, Year)	
1/	2+1		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) A # 103 F7. Was may de un 207.	44
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 8 2008  32. Registrar's Signature		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 December 10:00 AM Ruth Marguerite Lemley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3706 Knox Rd. Edgewater Anne Arundel 8. Date of Birth (Month, Day, Ye 1/6/1911 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F Days Hours Min. Director 146-12-6796 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3706 Knox Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Secretary Auto 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Gager Laura Hagerty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara W. Patterson/Daughter 14 Midland St., PO Box 87, Quogue, NY 11959 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Kalas Crematory 12/3/08 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiomyo /Medical Due to (or as a consequence of) Examiner RESTRASION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 XI Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check onl and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric C. Marcalus, M.D. 3169 Braverton St., Ste. 101, Edgewater, MD 21037 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2008 Registrar

DHMH 17 Rev 1/2001

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	Dhuaisian		Decedent's Name	First, Middle	, Lest)							2. Date	of Death	Day	Year	3. Time of Death
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5	s 1 end f Health tem 27 other tr	2	Da. Method of Disp	osition			20b. P	lace of Dispo	sition (Name o	of r place	a)	Date	20	c. Location -	City or Town	n, State
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of/			1 □ Yes 2 <b>X</b>			1 Inpatier	- 7	ER/Outpatien		Othe	4 Nursin	g Home 5				
	fter t uners	5   2	<ol> <li>Menner of Death</li> <li>Matural</li> </ol>	5 Pending	9	Date of Injur Month, Day	Year)	28b. Time of Injury	28c. I			28d. De:	scribe how	injury occur	red	
Sio	Attanding or death.  octor: Afte by the fune tiffication	3	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ot be						Yes 2 □ No	006 1	-ti (Ct	and an and Advanced	on the Person of the	Zavia Miranhar
Division	tal or Attanding P is efter death. al Director: After t led in by the funers Certification:		4 Homicide	determi	ned 200. I	Plece of Inju building, etc	ry - At ho . (Specify	me, tarm, str /)	eet, factory, off	tice			or Town,		er or Hurai r	Route Number,
	orai D		On Contif:	Marie	Dhual-l	a sha bees	4 may lene	wlades dec	. oooueend at th		o data and -!	no and dire	to the es:	co(c) cod	nnor en et-t	od
	To the Hospital or Attanding Phwithin 24 hours effer death. To the Funeral Director: Atter th completely filled in by the funeral Medical Certification:		9a. Certifier (Check only one)		Physiclen: To examiner: On to and		examinat						time, date	e and place,	end due to th	ne cause(s)
	Within To the Com	2	9b. Signature and	vile of certifier					29c. Lic	cense	number		290	d. Date signe	d (Month, Da	y, Yeer)
	d		► LADA	V	•				$\square DC$	$\mathcal{C}$	)516 <sup>L</sup>	13_	1	ec 2	<u>, 206</u>	28
	C,	3	D. Name end addre	ess of person v						7		oder	- 17	MAN	n	20
			HIVAN 6	Thah	1,51	· Ih	nm?	aci Inl	1050r	1	Ir Fr	ader	ICK	1/11)	1116	1.7

DHMH 16 Rev 6/95

State Registrar Goale

31. Date filed (Month, Day Yeer) 4 2008 32. Registrer's Signeture

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cheryl Lynne Lambert

neryi Lyiine La	1	For State  Certificate of Delegation		Reg. N	lo. 20	08 1.000
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da     December 10	y Year	3. Time of Death 2144 hrs
Medical Exami		Chery1 Lynne Lambert  4a. Facility Name (if not institution, give street and number).  4b. Cit	y, Town, or Location of Deat		, 2008 4c. County of Death	
;		,	nham		Prince George	
Funeral			nder 1 Year If Under 24Hr			hplace (State or Foreign untry)
Director		130-44-5772 1 M 2 X F 49 Yrs. Mo	nths Days Hours Mir	Dec. 30,	1050	oming
any	ı	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	5	Maryland Prince George's Bowie				1 X Yes 2 No
Maryl Maryl	rector	10e. Street and Number	Zip Code	10g. (	Citizen of What Cour	ntry?
34 th with the ems 23a out the notifie	a Dir	12332 4331-1-1-1	0720 edent of Hispanic Origin? ( S	US Specify Yes or No-		can Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	ecify Cuban, Mexican, Puerto		White, etc.	carr indian, black,
firer dear		1 Yes 2 X No 3 X Widowed 4 Divorced If Yes Give Year 1 Yes	2X No specify:		Specify: Whit	:e
hours afte	bg p	during most of	ual Occupation (Give kind of working life. DO NOT use re		b. Kind of Business/	ndustry
36 in 72 h	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)			) a = 4 = 1	
-00; d with ygiene ther t	S	2 Dental Hy 17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	Dental len Surname)	
21215-0036 2uld be filed within 7 I Mental Hygiene. is marked other than ic event, the Medica	Be	John Hilliard	Lynne C			
AD 21 2 should h and Mer 27 is mar	유		ress (Street and Number or		•	11
- P = # E #	1	John R. Hilliard/ Father 408 St.  20a. Method of Disposition 20b. Place of Disposition (	George's Cou	rt Satelli Date 20	te Beach. Oc. Location - City or	FL 32937 Town, State
Baltimore, permit. Pages I an Department of He Important: If ite	П	1 Burial 2 X Cremation 3 Removal from State crematory or other pla	ace)	/15 /0000		, ,,,,,
Baltimo permit. Page Department ( Important: injury or otl	1	4 Donation 5 Other Specify: Atlantic Cre 21. Signature of Funeral Service Licensee 22. Name	ematory 112/ and Address of Facility Ro	/15/2008   (	zans Funei	ral Home
Balt permit. Depart Import injury		John Library 16000	) Annapolis R	oad Bowie	MD 20715	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line.	de of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Citalopram intoxication Due to (or as a consequence of):	on			Death
		Sequentially list conditions,  b.				
	ner	if any, leading to immediate cause. Finter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, Trate be executed 5 physician and the burial - transit		d.  AMENDED 23a,27,28a-f, pe	ermE. 9887 1/	14/09 TT		<del> </del>
60, ate be ex obysician	Medical	ZY ON ENDED		14707 11	23d. Date of deliver	
3876 rtificat ing ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	ath 3 Ectopic pregr	nancy		Day Year
Box 687  E death certific  the attending p	Physician/	4 Pregnant at time of death 5 Other (i	Specify)			1
ords, P.O. Box 687  w requires that the death certific s been signed by the attending I should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
, P.O. res that the signed by be detack	d by			1 Yes	2 ✔ No 3 Pro	bably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requints after death.  at Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Reco The law cate has page 2 sl	E			performe 1 ✓ Yes 2	d? death? No 1 ✓ Y	es 2 No
tal Rections: The certificate ector, page	Be C	25. Was case referred to medical examiner? [Hospital: 4   Inpatient 2   EP/Outpatient 3	26.Place of Death (Chec			
f Vi Physic er this eral dir	٤	1 ✓ Yes 2 No Prosperied 1 Inpatient 2 ✓ ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Nurs  28c. Injury at Work?	sing Home 5 Re 28d. Describe how	sidence 6 Othe	r;
on of nding Pl tth. r: After ne funera	tion:	1 Natural 5 Pending FD 12/10/08 FD 8.44 r	4 Van 2 Trhia	unk		
Vision or Attendent offer death Director:	fica	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc.	28f. Location (Stre	et and Number or R	ural Route Number, City arter Horse
Divipital o	Certification:	4 Homicide determined (Specify) found at home		Dr. Bow		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, i and manner stated.	t the time, date and place, ar n my opinion, death occurred	nd due to the cause(s d at the time, date and	) and manner as sta I place, and due to t	ted. ne cause(s)
F W F 8	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo	
		D-n-Oil imo	O.C.M.E.		December 11, 2	008
26		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore,	MD 21201		
	tate					
Regis	tate	31. Date filed (Month, Day, Year)  DEC 1 6 2008  37. Registrar's Signature  Leven S. Sparks				

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar	otate of iviaryiar		tificate of		Wieritarriy	Reg. No.	1118	1.0021
an cal	1. Decedent's Name (First, Middle, Las ROBERT G. MARE	BURY SR.				2. Date of De	-	2ď8	3. Time of Death-
er	4a. Facility Name (If not institution, give WASHINGTON ADVENT			4b. City, Town, o	r Location of Dea IA PARK	th		y of Death GOMER	Y
	577 50 2021		(ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	9. Birthp WASH	place (State or Foreign INGTON, DC
<u>ا</u>	Usual Residence of Decedent  10a. State 10b. County  DD TNICE		ty, Town or Lo					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
Directo	MD PRINCE  10e. Street and Number  11354 CHERRY HILL		ELTSVI	10f. Zip Code 20705			10g. Citizen of		ntry?
Be Completed by Funeral Director	11. Marital Status  1 □ Never Married ♣□ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No		Specify Yes or No rto Rican, etc.)		ice - Americ ack, White,	can Indian,
pleted	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	16a, Deced (Give life, L	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)		16b. Kind of E		dustry
Com	Elementary/Secondary (0-12)				PAINTEI	me (First, Middle	PRIV.		
To Be	NATHANIEL MARBURY				NANCY 1	PARKER			
	19a. Informant's Name/Relationship (7 JUANITA MARBURY/W	ype. Print) VIFE	19b. Mailir 11354	ng Address (Street CHERRY	and Number or F HILL RD.	BELTSVI	per, City or Town LLE, MD	, State, Zip • 207	Code) 05
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 월 Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	sition <i>(Name</i> of natory or other place E CREMATO	DRY 1	Date 2/10/08	20c. Location BELTS		
	21. Signature of Funeral Service Ligen	Myon hel	0.	2. Name and Addre	,	CAPITOL .			20002
	23a. Part f. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SEVERE	th. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
1	Sequentially list conditions,	b	IIA						
kamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		EMIA						
dical E		AZOTEMIA	4401100 01).						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	⊒Ectopic pregnancy ] Other <i>(specify)</i> _	/			ate of delive	ery Day Year
d by Pr	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.				he cause of death?
Complete						24a. Was auto perfi 1 Yes		prior to con death?	ppsy findings available mpletion of cause of
Be	25. Was case referred to medical examiner? 1 ☐ Yes 💥 No	Hospital: 1X Inpatient 2	] ER/Outpatier	ot 3 DOA Oth	er _	eath (Check only		h (0if	
tion: To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur Wor		Home 5 Res	how injury occu		<u>n</u>
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rura	al Route Number,
Medical Certification:		ysician: To the best of my kn niner: On the basis of examin and manner stated.							
Me	29b. Signature and title of certifler	n el	els no	29c. Licens D20	e number 129		29d. Date sign	ed (Month,	

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 8 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHACKO MD.

**ACHANKUNJU** 

7610 CARROLL AVE., SUITE 390 TAKOMA PARK, MD. 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 (10) 8 1 1 1 1 2 2

		1 - State Registrar	(	Certificate of	Death	1	Reg. No.		1 0 0 4 4
Dhusia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea		V	3. Time of Death
Physic /Medi		Richard Franklin M	aranto Sr.			Nov.	29, 2	:008	11:13 PMM
Exami	ner	4a. Facility Name (If not institution, give street	· ·		r Location of Death			ty of Death	
, É		Anne Arundel Medical		Annapol:				Arun	
Funeral Director		5. Social Security Number 6. Sex 11-26-4940 1X M 2	□ F 74 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 1/12/	h 1934	9. Birthi Coul	place (State or Foreign ntry) PA
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town of	r Location				1	0d. Inside City Limits
Maryl f sho	ō	MD Anne Arunde						Ι.	1 ☐ Yes 2 ₹ No
the 28a	Director	10e. Street and Number	1 01010011	10f. Zip Code	-		10g. Citizen of	What Cour	
3a ol	a D	2088 Pear Hill Ct.		2111	+		US		,.
deatl	Funeral		is Decedent Ever in U.S.	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spe	ecify Yes or No-	14. Ra	ice - Americ	
d within 72 hours after giene. er than "natural", or ite		1 ☐ Never Married 2 🗗 Married 1	med Forces? Aves 2 □ No 53 − es, Give	1 □Yes 2 □ No	Specify:	Rican, etc.)		ack, White,	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Medical Even.	d by		ar or Dates: 56	1 1 1 e s 2 A 1 e s	Specify.		Speci	fy: Whi	te 
"natu	Completed	15. Decedent's Education (Specify only highest grade comp	oleted) ((	ecedent's Usual Occup Give kind of work done	durina most of worki	ng	16b. Kind of E	Business/In	dustry
withir ene. <b>than</b>	Ę	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	fe. DO NOT use retired nptroller	3)		Const		on
filed Hygi ther		17. Father's Name (First, Middle, Last)		mp or or recr	18. Mother's Name	(First, Middle			OH
e d la	To Be	Anthony Thomas Maran	to		Margaret				
d 2 should be th and Mental 7 Is marked of traumatic eve	Ĕ	19a. Informant's Name/Relationship (Type. Pri		lailing Address (Street				Stata Zin	(Code)
12 Tha	1	Janet Maranto (Wife		88 Pear Hil					. 6646)
- T 5 =		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place		ate	20c. Location		wn, State
Pages nent of int: If its iry or o		1 XBurial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)		eran Cemete		2008	Crowns	ville	• MD
permit. Page Department Important: If any injury or		21. Signature of Funeral Service Licensee		22. Name and Addre Hardesty F					
9 9 E E 8	1 0	190 g. J.		851 Annapo	olis Rd. G	ambrill	s. MD	21054	
		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do not se on each line.	enter the mode of dyir	ng, such as cardiac c	r respiratory ar	rest,		Approximate Interval Between
Physician	e (ii	Immediate Cause (Final disease or condition	/ /	Ms (6	MCG				Onset and Death
/Medical		resulting in death)	Due to (or as a consequence of)	1)	7107			-	
Examiner		Sequentially list conditions. b							
ed	Examiner	cause. Enter Underlying	Oue to (or as a consequence of):						
executed n and ial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a consequence of):						
be e iician buria			rac to (or as a consequence or).						
certificate be iding physicia se as the buri	Medical	d						-	
certi nding se a		iF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy				22d D	ato of dolive	NP.
death ne atter ed for u	ciar	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3  Ectopic pregnanc 5 Other (specify) _	у			ate of delive onth	Day Year
the cachec	Physician		Unknown						
law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing	ng to death but not resulting in th	e underlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
quire en sig uld b						dely	es 2□No	3☐ Prob	ably 4 Unknown
aw re Is ber 2 sho	Completed					24a. Was a		Were auto	psy findings available
The la ate ha	E O					autops	med?	prior to coi death?	npletion of cause of
lan: rtifice stor, p	Be C	25. Was case referred medical	/		26. Place of Death		2 DNo   ne)	1 ☐ Yes	2∐No
Physician: r this certific ral director, p	0	examiner? 1 Yes 2 No Hospital	: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Othe				her (Specifi	v)
ng Pt fter th	J:T	27. Manner of Death  Natural 5 ☐ Pending	Date of Injury 28b. Tim (Month, Day, Year) Inju			8d. Describe h			<i>,</i>
endir sath. or: A he fu	atic	2 Accident investigation			Yes 2□No				
or Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	2	8f. Location (S City or Town	treet and Numi n, State)	ber or Rura	l Route Number,
oital curs af									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner: On	To the best of my knowledge, do the basis of examination and/of	eath occurred at the tire rinvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and m late and place,	nanner as s and due to	tated. the cause(s)
the or the omple	Med	29b. Signature and little of certifier	d manner stated	29c. Licens					
¥ ¥ ¥ 8	_	255. Signature and plug of coulings	Unal me	)   250. Licensi	844	2	29d. Date sligne	Cy /	CONTRACTOR
KXX\		20 Name on the Section with the	d control of dooth (Norw CO.) (T	no Duint	0 110		1/2	1/	7 2
SA	0.00	30. Name an ss of person who mplete	d equise of death (Item 23a) (Ty	pe, Print)	1 it, 11	11/1-	Ho	700	1,11
Sta	ite	31. Date filed (Month, Day, Year) DEC 0 4 2008	32: Registrar's Signature	- 101	1	140)	/1 /*	17/00	1101
Registr		DEC 0 4 2008	Decree H 1	Sand a	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Joy DeFabio Menzel 2008 Donna December 3:50 Рм 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖫 F Months 579-64-6126 61 9,1947 Washington,DC February Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Hillcrest Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Colebrooke Drive 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ho Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Secondary (0-12) College (1-4or 5+) Teacher County Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh DeFabio Florence M. Niemier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dino Vinciguerra - Executor 3100 Ritchie Rd., Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 12/17/2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760. P.O.

The law requires that the death certificate be executed tran and attending physician a for use as the burialthe signed by the Division of Vital Records, peen has page this After 1 Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

death with

Director

Funeral

Completed by

Be

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7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the fredical Erani incrinual to invitine a

and 2 should be filed within 72 hours after of leatth and Mental Hygiene. m 27 Is marked other than "natural", or iter

Health em 27 I

Pages 1

permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tonce.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

within 2

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ Completed 25. Was case referred to medical Be Certification: To 27. Manner of Death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only one) 29b. Signature and title of certifier

> DOD52999 nunde

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI RAHIMIAND MD 104-03

HOSPITAL DR. GG CLINTON MD RAHIMIANOMD

31. Date filed (Month. Day, Year) DEC 0 8 2008

32. Registrar's Signa

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Katherine Evans Mitchell 26, 2008 6:20 PM November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolitan Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2**X**XF Feb 6, 223-18-6182 92 1916 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 Edwards Road 21409 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXX No Specify Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Clerk State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) Lillian Drummond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**Physician** /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be rediffed at once.

Baltimore, Maryland 21215-0036

**Physician** 

**Examiner** 

Funeral

**Director** 

/Medical

10a, State

Director

Funeral

Examiner

attending physicien and for use as the burial-transi signed by the a cate has been sip page 2 should b After this al or Attending F s after death. I Director: After d in by the funera

Physicien: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

completely filled in by To the Hospital within 24 hours a To the Funeral D Medical Registrar

<u>ک</u> 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Be William Jessie Evans ပ္ 19a. Informant's Name/Relationship (Type. Print) Lillian M. Peddicord/ Daughter 631 Edwards Road Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XIX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Belle Haven Cemetery 12/3/2008 Belle Haven, Virginia 22. Name and Address of Facility John M. Taylor Funeral Home. Inc. 21. Signature of Funeral Service Licensee Mil 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 1 Yes 2 Dec 5 Other (specify) 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes ✓ No Hospital: Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Assuleo 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 🗆 Yes 2 🗆 No 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57028 December 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 600 Ridgely Ave. Suite 231 Annapolis, Maryland 21401 Aditya Chopra
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2. Registrar's Signature

DEC 0 3 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Huldah Elizabeth Murphy ovembe 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X F 82 July 7, 579-22-2359 1926 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits X Yes 2 □ No Bowie Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12705 Millstream Drive USA 20715 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Nadine Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Klaassen/ Daughter 3317 Mont Clare Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 12/3/2008 Brentwood, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service da Ul 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final eum on La disease or condition resulting in death) de Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease v. Hjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

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Director

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ed other than "natural", or items 23a or 28a-f show event, the Medical Experiment nest be redified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter may Injury or other traumatic event, the Mydical Extraulisms.

Baltimore, Maryland 21215-0036

burial-tran

The law requires that the death certificate be executed ng physician as the burial signed by the attending I

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Examine this certificate has been sral director, page 2 should funeral After

Certification: To Medical

To the Hospita Community within 24 hours after death.

To the Funeral Director: After a community of the funeral principle of the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and the further and State Registrar

Physician/Medical þ Completed 25. Was case referred to medical examiner? Be 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No

1 ☐ Yes 2 ☐ Mo

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 1 ☐Yes 2 ☐No 2 No

20200

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 Inpatient 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo toplasonge

Hospital:

5 Pending investigation

6 ☐ Could not be

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

DEC 0 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 25, 2008 **Physician** 2:45 P. M Bertha Dorothy Mohr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heritage Harbour Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔽 F Yrs 11, 1925 Pennsylvania Director 83 July 157-16-9169 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Prince George's Bowie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 U.S.A. 3014 Belair Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or ite 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Rokaszak Frank M. Lanczak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Kerry Lockwood/Daughter 3532 Northshire Lane, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park Cemetery 12/01/2008 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, fraise 901 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) urs after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 -No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

within 2

Medical

Box 68760.

P.O.

Division

Mirza Nusairee M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1667 Crofton Center #1 Crofton, MD 21114

and manner stated

DEC 0 3 2008



29c. License number

29d. Date signed (Month, Day, Year) 08

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				artment of Health ertificate of Death	Re	g. No. 4000 110821
I	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Dee Arthur Mack		2. Date of Death Month November	3. Time of Death
- Sanda	Examir		4a. Facility Name (If not institution, give street and number)	4b. Cify, Town, or Location	of Death	4c. County of Death
	E		BWMC  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Glen Burn		Anne Arundel
	Funeral Director		411-28-3920 <sup>†</sup> X <sup>™</sup> 2□ F 81 Yrs.	Months Days Hours	Min. Apr 9	9. Birthplace (State or Foreign Country) Mississippi
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e Mar 3a-f sh	Director	Maryland Anne Arundel Annapol	is		1X1 Yes 2 □ No
	with th		10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	death ms 23	Funeral	223 Gross Ave  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21401 Was Decedent of Hispanic Ori	igin? (Specify Yes or No-	USA  14. Race - American Indian,
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  9d other than "natural", or items 23a or 28a-f show event, I'm Modicel Evarinar must be northed at	by	1 Never Married 2 Married 1 Married 2 No	If Yes, specify Cuban, Mexicar  1 □Yes 2 No Specify:		Black, White, etc.  Specify: Black
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Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee  Tarry 13. Rease Moc483	Mame Readse of Gallig 21 West St.	Sons Mortua Annapolis,	ry, P.A. Md. 21401
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<b>.</b>	ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
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		Medical	29a. Certifier (Check only one)  1 ertifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the caus th occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	within com	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
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Registrar

State

KONALD

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

4 CulwELL DR. PO.BOX 210 A/+ Airy

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 117/29/2008 Alice Virginia McMath Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2500 watersie Dr. Condo 315 Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 107271924 1 □ M 2 □ F Days Hours Min. 217-12-2440 84 Director Usual Residence of Decedent Show 10a State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinat must be notified at MD Frederick Director Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Waterside Dr. Condo 315 21701 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>homemaker</u> own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Emmert Adkins Alice Brandenburg permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles McMath (Son) 36985 Charles Town Pike, Hillsboro, VA20132 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 20b. Place of Disposition (Name of centre place) 20a. Method of Disposition 2 Cremation ArlingtonNational 12/18/2008Arlington, Va Donald B's Thompson Funeral Home POB 18, Middletown, MD 21769 a Part 1. Errer the disease, or complicati that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart failure. List only Immediate Cause (Final **Physician** Clevosis Coronany THENO 7 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Dav ed by the a detached for Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown σ, signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 Residence 6 □ Other (Specify) After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Driath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation ours after death. leral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4795 12-03- 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOIL House Ave- townerias. Mn 21701 · KAZMI 814 DIBTE A MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 3 2008 >

Registrar

David M Murnane State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ . Decedent's Name (First, Middle, Last) 2 Date of Death Month Medical Examiner Month Day December 9, 2008 David M. Murnane 1614 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 710 Smith Street Salisbury Wicomico Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Hours 600-34-0503 21 1 X M 2 March 7, 1987 Country) Arizona Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits show MD Anne Arundel Arnold Yes 2 X No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1266 Caddie Drive 21012 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14: Race - American Indian Black Armed Forces? 1 X Never Married Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Widowed Divorced f Yes, Give Year Yes 2 X No specify. Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 h
nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Medical than Compl 2 Student Salisbury University 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Michael R. Murnane Jennifer A. Trem 19a...Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Murnane/ Father 1266 Caddie Drive Arnold, MD 21012 Baltimore, I permit, Pages 1 and Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 11 20c. Location - City or Town, State Atlantic Crematory Burial 2 X Cremation 3 Dec Removal from State 2008 Glen Burnie, MD Other Specify Donation ignature 22. Name and Address of Facility Barranco & Sons 495 Gov. Ritchi Ritchie Hwy, Severna Park Funeral H Ritchie Hwy, Severna Park, MD 21146 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Cardiac arrhythmia Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Biventricular hypertrophy with myocardial fibrosi-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED PI line a-b, 27, perME, g886 12/23/08 TT attending physician or use as the burial X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 3 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 V Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ٩ 1 V Yes No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: Pending within 24 hours after death.

To the Funeral Director: Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) completely filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Vedical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 10, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Mont) Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year Ruth Marie Jackson Mason December 4, 2008 1805 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. May 26, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F 220-30-3639 77 Yrs. 1931 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f ehow event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 96 North Main Street or Iteme 23a 21904 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: 3 ♥ Widowed 4 □ Divorced White "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence Pages 1 and 2 should be filed nent of Health and Mental Hyginnt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chester Jackson Frances Murphy ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ralston (Daughter) 428 Colora Road, Colora, Maryland 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Its eny Injury or ot ong Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/08/08 Rising Sun, Maryland Brookview Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perrvville, Maryland 21903-0766 21. Signarure of Funeral Service License Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Renal Immediate Cause (Final F) cute **Physician** WK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inhibitation cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Jivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 Mb 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cro 1 ☐ Yes 2 **N**o 3 Probably 4 □Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 DOA this Alter thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation the Hospital or Attending 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the hest of my knowledge, death oncurred at the time, date and place, and due to the nause(s) and not me as stalled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Whay 032609 145108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1100 fevolution St How rede Gran moz1078. Milhanims Kamnudun 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 0.8 2008 Registrar

DHMH 17 Rev 1/200

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ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	or other plac	ce)	_	organto	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) and manner stated.					
	Son with	2	29b. Signature and title of certifier	29c. Licens	e number	1/ 29	d. Date signed (Mo	nth, Day, Year)
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-09280 elyn MaClary		- For State	aryland / Depa	artment of rtificate of	Health and	Mental Hy	giene		108 1083
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edical Exami		Evelyn Pecke  4a. Facility Name (if not institution, give street	t Macla and number)	ary 4	b. City, Town, or L		December	4c. County of D	
		Peninsula Regional Medical Ce			Salisbury		7250	Wicomico	
Funeral Director		5. Social Security Number 6. Sex 197–12–1118 1 M 2	7. Age (In yrs. I. 85	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt		Birthplace (State or Foreign Country) Pennsylvania
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5-0036 Tled within 72 Hygiene. d other than 's	Comple	17. Father's Name (First, Middle, Last).		CTEL		18.Mother's Name	(First, Middle,		vermient
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ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours of Feaths and Mental Hygiene. The max is marked other than "natur ther transmatte event, the Medical Exam		20a. Method of Disposition	20b.	Place of Dispos	ition (Name of cer		Date	20c. Location - C	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mernal I Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 X Cremation 3 Re	moval from State	crematory or oth	nerplace) Cremato	rv   12/2	12/08	Salisbu	rv, MD
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Box 68760, e death certificate be the attending physici ed for use as the buri	Completed by Physician/Med	IF FEMALE: 23 23b. Was decedent pregnant in the	c. If yes, outcome of pre		etal death 3	Ectopic pregna	ancy	23d. Date of do Month	elivery Day Year
× 68 th certi	iciar	past 12 months?	Pregnant at time of o	dooth	ther (Specify)				
. Bo the dea y the a	Phys	Part II. Other significant conditions cont	Unknown ibuting to death but not	resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
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Vital Reorysician: The his certificate director, page	B C	25. Was case referred to medical examiner?				Other Nursin		Durida A	Other
F Vit Physic er this c	⊢	1 V Yes 2 No	al: 1 Inpatient 2	ER/Outpatien		ury at Work?		Residence 6 how injury occurre	
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Division of Vital Records, pital or Attending Physician: The law require ours after death. After this certificate has been sifiled in by the fitneral director, naez 5 should 8	ficat	2 X Accident Investigation 3 Suicide 6 Could not be	12/9/08 28e. Place of Injury - At	15:00 r home, farm, stre	eet, factory, office	building, etc.	28f. Location	(Street and Number State) 3312	r or Rural Route Number, City High Sea Dr A
Div spital o	Cert	4 Homicide determined	(Specify) resid						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici Tron here Fulled in by the funeral director.	Medical Certification:	29a. Certifier 1 Certifying Physician: 1 one) 2 Medical Examiner: On 1	o the best of my knowle he basis of examination manner stated.	edge, death occu n and/or investiga	arred at the time, o ation, in my opinio	n, death occurred	at the time, dat	e and place, and du	e to the cause(s)
F 3 F 8	ິ  ≥ຶ	29b. Signature and title of certifier			29c. Licen			29d. Date signe December 1	d (Month, Day, Year)
			<i>ι</i> ο		0.0	.M.E. 		December	
	al .	30. Name and address of person who comp  Donna M. Vincenti, MD Ass	leted cause of death (Ite istant Medical Ex		1 Penn Stree	t, Baltimore, N	/ID 21201		
	State	250 4 8 2000	32. Régistrar's Sign	ature	ente				
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Box 68760, P.O. Division of Vital Records, After

State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** Raymond Mechak 8:45 a December 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Angel's Garden, Silver Spring Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 27, 1922 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 1922 86 Director 186-14-6463 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: 'or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic events. 1 ☐ Yes 2X No Directo Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Golden Grass Court 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★▼Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or ite **½**Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify. White 1 ☐ Yes 2 ☐ No Specify: \$ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Store Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Mechak Anne Sivillich ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Mechak/Son 5 Golden Grass Court, Owings Mills, MD 21117 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. MD Veterans Cemetery Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure To Thrive weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Alzheimer's Disease vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 □ Yes 2 No 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Group Home 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27 Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1x Natural 5 Pending within 24 hours arter containing the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 Medical (Check only one) and ma 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D38457 December 4, 2008 30. Name and address of perso completed cause of death (Item 23a) (Type, Print) 2801 International Drive, Silver Spring, MD 20906 Nakul Goyal, MD 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh 887 1-5-09 vt
State of Maryland Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 8:35 aM Marcellina Estella Matthews 28 2008 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

May 26 1006 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖾 F Yrs. 99 Director 578-15-8698 -26, Sierra Leone Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20906 Sierra Leone 2407 Glenallen Avenue death \ by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Ments 27 is marked traumatic e Tiawo Teckham ည Henry Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trace Marcella Leigh - Daughter 2407 Glenallen Avenue, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Dother (Spegfy) 12/19/2008 Silver Spring, Maryland 21. Signature of Funer J Servi 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. one 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the is ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, healing harmonic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myocardial Infarction Examiner Due to (or as a consequence of) physician and the burial-transit Hyperischemia Due to (or as a consequence of): Box 68760, Physician/Medical Failure to Thrive attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) nours after death.

neral Director; After this confilled in by the funeral dire Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shamahang D60826 November 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 5 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Maguire 150 A M Decemb 8008 115 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard orien Columbia Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months Days 8/28/1919 Milton, DE. Hours Min. 1 □ M 2 🕅 F 89 222-01-3920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at MD Howard Columbia 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 5615 April Journey USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No White Specify Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Library 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe James Turner unknown Pages 1 and 2 should ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5615 April Journey Columbia, Maryland 21044 Patricia Mason/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 12/06/2008 Wilmington, DE. Cathedral Cem. 4 Donation 5 ☐ Other (Specify) uneral Service Licens PHILIP D. RINALDI FUNERAL SERVICE, P.A. 21. Signatur 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Highbrude Non-Hodgkin ippars disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical as attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 ☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 1 No

Physician /Medical Examiner

3altimore, Maryland 21215-0036

s certificate has b lirector, page 2 sl To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 2 Certification:

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? Hospital:

5 ☐ Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

N0059423

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

teinberg 31. Date filed (Month, Day, Year)

DEC 0 5 2008

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

6030 Daybreak Circle Scite A150-236 Clayleyille, MD 21029 32 Registrar's Signature

State Registrar

Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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, K	Examir	er	124 Valley View					Landing		4c. Count	Arun	del		
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir			place (State or Foreign atry)		
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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d, Inside City Limits		
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	or 282	Jirec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?		
	23a c	ra [	124 Valley View	Farm Ln.			20779				USA			
	er de? items	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. V	Was Decedent of F f Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	)- 14. Ra Bla	ce - Americ ick, White, e			
21215-0036	urs aff	ρ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give <sup>21</sup> Year or Dates:	10	1	l∐Yes 2 <b>X</b> No	Specify:		Specia	<sup>fy:</sup> Wh	ite		
2-0	72 hou	Completed	15. Decedent's Ec (Specify only highest gra	lucation		16a. Deced	lent's Usual Occup	oation	e sking	16b. Kind of B				
21	ithin 7 ne. han "r	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	kind of work done OO NOT use retired	d)	rorking					
2	Hygie Hygie ther ti nt, in		17. Father's Name (First, Middle, Last)	2 years		Mortg	age Audi		ame (First, Middle		1 Est	ate		
Maryland	s should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mydical Exa of the most be notified at	To Be	Bobbie Ric		n				anne Gibb		nej			
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)		
	1 and 2 Health a tem 27 is		L. Mark Newman/ H	usband					Ln., Tr	acys La	nding	,MD 20779		
ore	Jest toff Hiter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State			sition (Name of natory or other plac		Date	20c. Location	•	•		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important; if item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Aradical Eva ciner must be purified in once.		4 ☐ Donation 5 ☐ Other (Specify	<i>(</i> )	Our		of Sorro	1				Maryland		
Bal	permit. Pages 1 Department of H Important; If ite any injury or of once.		21. Signal of Funeral Service Licer	George P. Land Rd.										
		9 113	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death e.					rrest,		Approximate Interval Between Onset and Death		
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Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	=0.00		23d. Da	ate of delive	ry		
O. B	requires that the death cer been signed by the attendir hould be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	У		Me	onth	Day Year		
σ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death bu	t not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?		
Vital Records,	equires en sign	ed by							1 🗆 `	Yes 2 No	3 ☐ Prob	ably 4 Unknown		
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<u> </u>	The law i	E O								rmed?	death?			
Vita	Physician: The lav this certificate has ral director, page 2 a	Be	25. Was case referred to medical examiner?	Hospital:			Tous		eath (Check only o	nne)				
o	ys Si Si	<u>۽</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier		R/Outpatient 28b. Time of	t 3 ☐ DOA Oth	4 LJ Nursing	Home 5 Resid	dence 6 Oth		)		
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	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At hor	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb	ber or Rural	Route Number,		
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examinati	/ledge, death on and/or inv	occurred at the tile restigation, in my co	me, date and pla ppinion, death oc	ice, and due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier	A			29c. Licens	e number	200	29 Date signe	ed (Mogth, E	Day, Year)		
			Atti cha)	1 He	W	m	1	) NY	38	Le ce	when	02,2008		
\	1200		30. Name and address of person who of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o	on pleted cause of de	ath (Item	23a) (Type, 5	Cint)	- A. C.	WAY A	NAIDPI	L/C M	02010		
	Sta	(a)			r's Signatu	ire_	110005	( O) H	W/ //	- OVINO	- 3 //	0) 0,40/		
	Sta Registra		DEC 0 3 2	008	42 4	K A	Coast 1							

DHMH 17 Rev 1/2001

3-09246 harles D. Poff,	Jr.	Please Type or Print in Black Indeli State of Maryland / Departme					ible.							
Physicia	F	- For State Registrar 1. Decedent's Name (First, Middle,Last)	ate o	f Death		Reg	100	3. Time of Death						
ledical Exami		Charles D. Poff, Jr.		4b. City, Town, or Locati		Month December 9	9, 2008 4c: County of Dea	1238 hrs						
		4a. Facility Name (if not institution, give street and number) 8007 Old Branch Avenue		Beltsville	·		Prince Georg							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) Yrs	Months Days Ho		8. Date of Birth March 2	(MM/DD/YYYY) 9. B Fore 2, 1964							
any		Usual Residence of Decedent         10c. City, Town           10a, State         10b. County         10c. City, Town	or Loca	tion				10d. Inside City Limits						
<b>*</b> .	tor	Maryland Prince George		nton			g. Citizen of What Co	1 Yes 2 XXNo						
or 28a	Director	10e. Street and Number 8007 Old Branch Ave		10f. Zip Code 2073	35		Jnited Sta	-						
eath with the Maryland items 23a or 28a-f sho	= -	11: Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No		as Decedent of Hispanic Yes, specify Cuban, Mexi	Origin? ( Spe	cify Yes or No-		erican Indian, Black,						
after d	by Fi	Wildowed 4 XXDivorced If Yes, Give Year or Dates:		Yes 2 X No spec			Specify: Wh							
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f She i, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	nt's Usual Occupation (G nost of working life. DO N Worker			16b Kind of Business Constru							
5-00; ed with ygiene ygiene other t	e C	17. Father's Name (First, Middle, Last)		18. <b>M</b> o	other's Name (	First, Middle, Ma	aiden Surname)							
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than or other traumatic event, the Medical	Be	Charles David Poff, Sr.			-	ileen B								
MD 212 d 2 should be th and Menta n 27 is marke numatic even	6			ng Address (Street and Orangewood										
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of cemetery			20c. Location - City							
MOF		Burnar 2 Polemation 5 Removal nom state	Donation 5 Other Schefits Lee Crematory Dec 11, 2008 Clinton, MD											
Baltimore, permit. Pages I at Department of He. Important: If ite		21. Significant Funeral Savice Licensee	Bollation 3 Jother Description											
4	-	26a Part I. Enter the disease, or complications that caused the death, Do no	Alexandria Ferry ROad, Clinton, MD 2073 <sup>th</sup> Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approximate Approxima											
Physician /Medical	1	failure. List only one cause on each line.				10		Between Onset and Death						
`xaminer		Immediate Cause (Final disease or condition resulting in death)  a. CONTACT SURSHOT  Due to (or as a consequence of):	wour.	id of chest										
	ě	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			77									
	Examiner	Colsease or injury that initiated events resulting in death) Last Unit (or as a consequence of):												
ecuted and transit		d	£	norME agg	6 12/22	ን /ሰያ ጥጥ		-						
5 5 =	edic	X UNPENDED AMENDED 23a,27,28a	<u>-</u> ,	perme, good	12/23		22d Date of dollar							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	sician/Medical	Pregnant at time of death	-	etal death 3 Eco	ctopic pregnan	псу	23d. Date of deliver	Day Year						
Boy le death the att	Physi	1 Yes 2 No 9 Unknown g Unknown				Loop Did to		to the cause of death?						
ires that the d signed by the		Part II. Other significant conditions contributing to death but not resulting	g in the	underlying cause given i	in Part I.	_	2 No 3 P	robably 4 Unknown						
Division of Vital Records, tal or stending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed by					24a. Was a autops	sy prior to med? death							
Vital Rec ysician: The l														
Vita vysicia this cel	To Be	O 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 4 Notising frome 3 Residence of Other Scene												
Sion of Attending Ph r death. ector: After t		1 Natural (Month, Day, Year)	Time of	1 Vec			ow injury occurred	f						
Sion Attender Treath Treath Treath Treath Treath Treath Treath	cati	2 Accident Investigation Fnd 12/9/08 Fd		30 pm =	ng, etc.	28f. Location (S	treet and Number or	Rural Route Number, City						
Divi	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc.  Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  Old Branch Ave												
To the Hosp within 24 hos Completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only)	ath occi	urred at the time, date an	nd place, and o	due to the cause the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)						
To the within To the comp	Medical	2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifler		29c. License nun			29d. Date signed (A							
		Caroe La Doar	_	O.C.M.E.			December 10,	2008						
4		30. Name and address of person who completed cause of death (Item 23a)			ND 0255		L	***						
Ψ			Penn	Street, Baltimore,	MD 21201									
S	tate	31. Date filed (Manth, Day, Year) 32, Registrar's Signature	A00-0	Charles and the second										

State 31. Date filed Worth, Day, gear 2008

## ease Type or Print in Black Indelible Ink. Ensure All Copies

			For State Registrar	riease	-		/ Depa		leaith ar	nd Mental Hy		9 0 0 0	40330	3
	Physici /Medi		1. Decedent's Nam	7	Phe	(ps				2. Date of De Month Novemb	eath Da	y Year 29 2008		v
	Examir	ner	1 -	4	street and number)			4b. City, Town, o		Death	40	: County of Dea	th	
			Lorien M 5. Social Security N		Clube 7. Ac	ge (In yrs. las	t birthday)	Mt, L	If Under 24	Hrs. 8. Date of Bir	rth	Carrol	( thplace (State or Foreig	
	Funeral Director		579-38-1 Usuel Residence of	589	☐ M 25€F	78	Yrs.	Months Days		Min. 8. Date of Bir (Month, Date of April 2	23, Year	930	thplace (State or Foreig ountry) DC	-
	show	_	10a. State Maryland	10b. County Frederic	l <sub>r</sub>	10c. City,	Town or Lo		<del>_</del>				10d. Inside City Limits  Yes 2 □ No	
	he Ma	ecto	10e. Street and Nu		.K	rred	er rer				10a Ci	times of Miles C		
	3a or 2	I DI		ghton Cou	rt			10f. Zip Code	21703			tizen of What Co SA	ountry ?	
	death ms 2	Jera	11. Marital Status		12. Was Decedent	Ever in U.S.	13.			n? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Ame		_
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ortant: If item 27 is marked other than "hat half item 28 is not injury or other traumatic event, it is Marked Examination to the trailing at 8.	Completed by Funeral Director	1 ☐ Never Marr 3 🙀 Widowed	ed 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 Tes, specify Cub 1 ☐ Yes 2 <b>K</b> No		Puerto Hican, etc.)		Black, White Specify:	white	
15-0	"natur	leted	(Spec	15. Decedent's Ed	fucation ide completed)		(Give	dent's Usual Occup kind of work done	during most o	f working	16b. K	(ind of Business	/Industry	
121	within ene. than	dmo	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		DO NOT use retire emaker	a)			Own ho	me	
	filled Hygi other ent, I			(First, Middle, Last)					18. Mother's	Name (First, Middle	, Maider		······································	_
an	Ald be Aental rked tic ev	To Be	Norman S	cott Ingr	an				Ada	Catherine	Bush	1		
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 la marked other than any injury or other traumatic event, II a M. ODGE.	_		ame/Relationship (				_		or Rural Route Numb	-			
	and 2 ealth n 27 I			helps - s	on				_	, New Mark				
Baltimore,	T iter		20a. Method of Dis 1 ☐ Burial 2		Removal from State	20b. Plac	ce of Dispo netery, crei	sition (Name of matory or other pla		Date	20c. L	ocation - City or	Town, State	
ţi	ment tant:		` 4 ☐ Donation	5 Other (Specif	y)			Cremator	_	2-2-2008			Maryland	
Bal	Depar Impor any in		21. Signature of Fu	neral Service Licer	1588					Stauffer F			yland 2170	na
	Physician /Medical Examiner		23a. Part1. on it shock, or hea Immediate ause disease or condition resulting in death)	(Final		llin-K	Do not ent	er the mode of dyi	ng, such as ca	rdiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death	,
	uted J ansit	Examiner	Sequentially list contains, leading to me cause. Enter Under Cause (Disease or	nditions, interiate ortying injury	b. — Dus to (or as	a conseque	nta of).							
,0928	ate be executed sysician and he burial-transit	cal	that initiated events resulting in death)	Last	c. Due to (or as	a conseque	nce of):							
.O. Box 68	The law requires that the death certificate to the law requires that the attending physis age 2 should be detached for use as the topage 2.	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[ 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3[	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year	
Records, P.	uires that the de signed by the a Id be detached t	by	Part II. Other signi	icant conditions of	ontributing to death t	out not resulti	ing in the u	nderlying cause gr	en in Part I.				o the cause of death?	n
COL	w require s been si should t	Completed								24a. Was	an	24b. Were at	utopsy findings available	9
Re	The lay	mo									ormed?	death?		
Vital		d)	25. Was case refer	red to medical					26. Place of	1 ☐ Yes f Death (Check only o		T T T T BS	2 No	-
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ion of	Jing After fune		27. Manner Deat  1 atural 2 Accident	5 Pending investigation		ury 29	8b. Time o Injury	Wo	ry at	28d. Describe				
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3  Suicide 4 Homicide	6 Could not b	286. Place of In	jury - At hom tc. (Specify)	e, farm, sti	eet, factory, office		28f. Location ( City or To	Street ar wn, State	nd Number or Ri e)	ural Route Number,	
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	To	2	29b. Signature and	title of certifier				29c. Licens			29d. Da	te signed (Mont	h, Day, Year)	
	0		20 No.	del -	m		20) (T		25942		Dee	ember 1	2008	
	4		10-1	ess of person who	completed cause of	Dazz	laro a f	CIROL S	, A Ai	50-236 C	las	sille N	21005 A	
	Sta	ate	31. Date filed (Mon			rar's Signatur	9	1 4						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma		epartment Certificate			nd M	-	giene Reg. No.	2008	instin
ï	Physici		1. Decedent's Name (First, Middle, La		Paugh					2. Date of De Month		08 <sup>Year</sup>	3. Time of Death  1:00 A M
1	/Medio		4a. Facility Name (If not institution, gi	ve street and number) ighway			rown, or l	Location of			4c. C	ounty of Death Garrett	1 1000 2
2.0 (%)	Funeral Director			Sex 7. Age	73 Yr	Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Oct 2.	th y, Year) 3 35	9. Birthp Coun Mary	lace (State or Foreign try) Land
	aryland show d at	_	Usual Residence of Decedent  10a. State 10b. County  MD County		10c. City, Town o							1	0d. Inside City Limits 1 ☐ Yes 🏋 No
	with the M a or 28a-f be notifie	Directo	10e. Street and Number 17839 Maryland	Hi abrazz		10f. Zip	Code				_	en of What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3/2 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates:	ever in U.S.	13. Was Deced If Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican, Specify:	in? (Spe Puerto l	ecify Yes or No Rican, etc.)	- 14	Race - Americ Black, White, Specify: Whi	an Indian, etc.
21215-0036	s within 72 hou giene. r than "natura the Medical E	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) Unkown	ducation rade completed) College (1-4or 5-	16a. D	ecedent's Usua Give kind of worn ife. DO NOT us Homemal	k done di e retired)	urina most	of workii	ng		of Business/Ind	dustry
Maryland 2	uld be filed Jental Hyg rked othe tic event,	To Be C	17. Father's Name ( <i>First, Middle, Las</i> <b>John Bosley</b>	t)				18. Mother Edre	's Name SSS	(First, Middle Elliott	Maiden S	urname)	
	and 2 shoresalth and No. 27 Is mader trauma		19a. Informant's Name/Relationship William Paugh/son		178	39 Mary	land	High			-	rown, State, Zip iaryland	,
Baltimore,	Pages 1 annuary of He		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec			disposition (Name crematory or of Cemetery		" 1	2/9/	08		tion - City or To	wn, State
Balti	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	Sil		22. Name and Westerr	nport	t,MD:	2156	2		Home, 111	Church St.
760,	Physician // Medical Examiner physician and physician sud physician sud physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is privately and physician sit is priv	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
P.O. Box 687	The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome  1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic pre 5 □ Other (spe					23	d. Date of delive	ery Day Year
	quires that n signed bi uld be deta	by	Part II. Other significant conditions	contributing to death bu	ıt not resulting in t	he underlying ca	use give	n in Part I.		23e. Did t			ne cause of death? ably 4
or Vital Records,	(0 □	Completed								1□ Yes	2 No	death?	psy findings available mpletion of cause of 2□ No
or Vit	Physiclan: this certific ral director,	To Be	25. Was case referred to medical examiner?		nt 2 ER/Outp			r: 4□ Nur	sing Hor		dence 6	□Other (Specif)	y)
Division (	Attending r death. ector: After by the funer	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatic 6 Could not determined	ne 290 Place of inju	Year) Inju	М		at ? ′es 2 □ N	10	28d. Describe 28f. Location ( City or To	Street and		l Route Number,
۵	Hospital or 44 hours afte Funeral Dir tely filled in I		(Check only 2 Medical Exa	hysician: To the best of aminer: On the basis of	examination and/	death occurred a	at the tim	e, date and	d place, a	and due to the	cause(s) a	nd manner as st	tated.
	To the I within 2 To the I complet	Medical	one)  29b. Signature and title of certifier	and manner sta	ted.	290.	. License	number			29d. Date	signed (Month,	1
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Tr	ype, Print)	1+2	501.	57	/	12	08	108
		3	Daniel Miller, N 31. Date filed (Month, Day, Year)	D ,69 Wolf	e Acres,	Oakland	,MD	21550					
	Sta Regist	_	DEC - 8	0.00	is Signature	Special	9						

DHMH 17 Rev 1/2001

	State of Maryland / Department of 1-For State Certificate of Registrar		/giene Reg. No. 2	008 4084							
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Eric L. Proctor		2. Date of Death Month Day Year November 24, 2008	3. Time of Death 0723 hrs							
(		4b. City, Town, or Location of Death Bladensburg	4c. County of Prince Ge	Death							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. 49 49 49 49 49 49 49 49	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		9. Birthplace (State or Weightington, D.(							
Maryland 28a-f show any 1.at once. ector		entwood Table Zip Code	10g. Citizen of Wha	10d. Inside City Limits 1 XX Yes 2 No							
oith the Maryland 23a or 28a-f she notified at once al Director	10e. Street and Number 3509 Webster Street  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13.	20722 as Decedent of Hispanic Origin? (Sp		American Indian, Black,							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? If Y 1 Yes 2 X No If Yes (ive Year or Dates:	Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.) White, Specify:	Black							
5-0036 cd within 72 hours of the wind within 62 hours he Medical Example.		nt's Usual Occupation (Give kind of w $\cos$ t of working life. DO NOT use retire $1$ e $ m c$	red)	el One, Inc.							
215-0C be filed win mul Hygier rrked other rent, the M	17. Father's Name (First, Middle, Last)  Irvin Proctor, Sr.	Ве	(First, Middle, Maiden Surname)								
MD 21 ad 2 should fifth and Me m 27 is ma aumatic ev	Erica V. Proctor (Daughter) 1359	g Address (Street and Number or F Stevens Road, S.	E. Washington,	D.C. 20020							
imore, Pages I an ment of Hea tant: If Itel	1 X Burial 2 Cremation 3 X Removal from State G1crematory or of Column 1 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column 2 Crematory or of Column	sition (Name of cemetery, the Class) tery  Dec.  Name and Address of Facility Mar	6,2008 Washing								
	G.P. Mayshall 42	D.C. 20011									
Physician Medical (xaminer	failure. List only one cause on each line.  mediate Cause (Final disease a. Asphyxia										
ner .	Sequentially list conditions, if any, leading to immediate  b. Hanging  Due to (or as a consequence of):										
red d ansit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.										
50, te be executed yysician and e burial - transit	UNPENDED AMENDED										
ox 6876 eath certifica attending pt for use as the	past 12 months?	etal death 3 Ectopic pregna ther (Specify)	23d. Date of d Month	elivery Day Year							
tal Records, P.O. Bo crian: The law requires that the decertificate has been signed by the ector, page 2 should be detached for Be Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribution 1 Yes 2 No 3								
(ecords, he law require ate has been signage 2 should b			autopsy pri performed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No							
al R	25. Was case referred to medical	26.Place of Death (Check									
F Vita Physicis r this ce al direc	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatien		g Home 5 Residence 6								
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page edical Certification: To Be Corr	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: FOUND: Nov 24, 2008 0721 hrs	1 Yes 2 ✔ No	28d. Describe how injury occurred Subject hanged self								
Divis	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed (Specify) Other (stairwell)		28f. Location (Street and Number or Town, State) 5800 Annapolis Rd., Bladenst								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred a	at the time, date and place, and due	e to the cause(s)							
• 4	29b. Signature and title of certifier  When Brasse Willow	29c. License number O.C.M.E.	November 2	4, 2008							
	30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 I	Penn Street, Baltimore, MD	21201								
State Registrar		W.									

Shelly Beth Ramire		Si For State	tate of Mar	ryland /	Departn Certific	nent of cate of	Health Death	and	Menta	ıl Hygiei		j. No.	201	ne .	131
	R	egistrar . Decedent's Name (First, Midd	dle.Last)			outo o.					te of Death		Year	3. Time of Dea	
Physician Medical Examine	er	Shelly Be	th Rami				b. City, Tov	vn or L	ocation of		nth cember		ity of Death	2039 hrs	
	4	a. Facility Name (if not instituti Frederick Memorial F		id number)			Frederi		R.			Frede			
Funeral Director		Social Security Number	6. Sex		(In yrs. last b	oirthday) Yrs	If Under Months	1 Year Days	If-Under Hours	Min		15, 19	Foreig	thplace (State of on <b>Mary]</b> untry)	land
Š.		Usual Residence of Decedent  Oa. State 10b. County	V		10c. City, Tov	wn or Locati	on							10d. Inside Ci	ity Limits
d d			erick		Fr	ederi	.ck							1 X Yes 2	2 No
te Maryland or 28a-f show	ᄓ	0e. Street and Number 240 Thames D					10f. Zip C		702		10	g. Citizen of USA	What Coul	ntry?	
death with the Maryland or items 23a or 28a-f sho	_ L	Marital Status     Never Married 2	Married Arm	s Decedent ned Forces?		13. Wa	s Decedent es, specify	t of Hisp Cuban,	anic Origi Mexican,	n? ( Specify Puerto Ricar	Yes or No- n, etc.)		Race - Amer Vhite, etc.	rican Indian, Bla	ack,
after de	교		Divorced If Yes, Giver Dates:	ve Year		1	Yes 2			ind of work o	tone	Spec	of Business/	white	
2 hour:	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12)	2) Colle	ege (1-4 or 5	5+)	a. Deceder during m	ost of work	ing life.	DO NOT	ind of work ouse retired)					
5-0036 Iled within 72 Hygiene. d other than	티	17. Father's Name (First, Midd	lle, Last)			10шеша		1	8.Mother's	s Name (Firs	t, Middle, I	Maiden Surn		Iome	
215- be filed ntal Hyg rrked of	å	James Ronald	Moleswo							a Ann			Taum Stat	o Zin Cada)	
21 should be nd Mer is mar	ျှ	19a. Informant's Name/Relatio												e, Zip Code) aryland	2170
b, MC and 2 s lealth a tem 27	-	20a, Method of Disposition				ice of Dispo	sition (Nam			Da		20c. Loca	tion - City o	or Town, State	
MOFE		1 X Burial 2 Cremat 4 Donation 5 Other		oval from St		Olive		ete	ry	12-12	-2008	Frede	rick,	, Maryla	and
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat	1	21. Signature of Funeral Service	ce Licensee				Name and					Funera		ne aryland	21702
Physician		23a. Part I. Enter the disease,	or complications	that caused	the death. D	o not enter	the mode o	f dying,	such as ca	ardiac or res	piratory an	est, shock, o	or heart	Approxima Between 0	te Interval
'Medical	1	failure. List only one cau Immediate Cause (Final disea or condition resulting in death	ase a. $02$	xycodo	ne and	l hydr									ath
<i>A</i>		Sequentially list conditions,	b											4	
	iner	if any, leading to immediate cause. Enter underlying Cau	ise c	or as a cons	sequence of):									_U	
ed nsit	Examine	(Disease or injury that initiate events resulting in death) La			sequence of):					/	c 100	<b>M</b> M		_	
execution and in and in a range	dical	X UNPENDED	AMEN	NDED 23	a,PII	,27,28	3a-f,	er,	MD G	387 17	6709	11			
760, cate be physic the bur		IF FEMALE: 23b. Was decedent pregnant i			ome of pregna		etal death	3	Ectopi	c pregnancy			ate of delive onth	ery Day	Year
OX 68760, eath certificate be executed a strending physician and for use as the burial - transit	Physician/Me	past 12 months?	4	Live birth Pregnant a	at time of dea		Other (Spe								
Box ne death c the attented for us	hysi	1 Yes 2 No 9 V		Unknown	ath but not res	sulting in the	e underlying	cause	given in P	art I.	23e. Did	tobacco use	contribute	to the cause of	death?
, P.O. B ires that the d signed by the	þ	Myofascial									1 Y	es 2 N	o 3 P	robably 4 🗸	Unknown
ords,  require s been si should b	Completed		-									opsy	prior t	autopsy finding to completion of	
ecol he law ate has age 2 sh	omp										1 Yes	formed? 2 No	death'		No
Vital Rec hysician: The this certificate	Be C	25. Was case referred to me- examiner?	dical Hospital						of Death	Nursing F		Residence	e 6 Ot	ther:	
f Vit Physic er this c	P	1 Yes 2 No 27. Manner of Death		a. Date of Ir	tient 2	28b. Time		OOA 28c. Inj	ury at Wor			e how injury			
on of \ nding Phy tth r: After the	tion:	1 Natural 5	Pending	(Month, Day	(,Year)	FD 8:	mq 00	1	Yes 2X	INO	nk ———				
Division of Vital Records, tal or Attending Physician: The law require is after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X	Could not be	8e. Place of	Injury - At ho	me, farm, s	reet, factor	y, office	building, e	etc. 28	Bf. Location	State 240	Number or MD	Rural Route No nes Dr	umber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide		Specify)		ge, death oc	curred at th	e time,	date and p	lace, and du	ue to the ca	use(s) and r	manner as s	stated.	
To the within To the comple	ledical			e basis of ex nanner state	xamination ar	nd/or invest			nse numbe		no timo, da	29d. Da	te signed (	Month, Day, Ye	ar)
	Σ	29b. Signature and title of certifier  O.C.M.E.  December 9, 2008													
		30. Name and address of pe	erson who comple	eted cause o	f death (Item aminer	23a) 111 Peni	n Street,	Baltim	nore, MI	D 21201					
s	tate	31. Date filed (Month, Day, Y	(ear)		trar's Signatu		parti								
Regis		DEC	1 2 2008	Here	yer b	J. 14	No. of the last				OCME				

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHELBY **Physician** 12 06 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTISTABITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral**  Date of Birth (Month, Day, Year) Months Hours Days Min 1 □ M 2√XF 439-50-6961 Director 1-23-1938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinating to refilled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X□Yes 2□No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 8830 PINEY BRANCH ROAD 20903 U.S.A. #205 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ۵ Specify: BLACK 3 √ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER NASA - U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PETER SHELBY IRENE HUNT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE L. GIBBS--DAUGHTER 8830 PINEY BRANCH ROAD #205 SILVER SP., MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PROVIDENCE MEMO. CEM. 12-20-08 4 ☐ Donation 5 ☐ Other (Specify) METARIE, LA 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part1. Enter the disease, or complications that caused the leath. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIO **Physician** HEART disease or condition resulting in death) SCLEROTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Vital 2 200 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 4 hours after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWITKES

31. Date filed (Month, Day, Year)

DEC 0 8 2008

WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARKIMD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 8 2008

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marie duPont Scarlett 28, November 2008 9:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1915 Whitehall Road Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours 213-50-2789 92 Jan. 27, 1916 Delaware Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 Whitehall Road 21409 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archibald M.L. duPont Elise Heyward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest D. Levering/son 14617 Dover Road Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 12/3/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final lad disease or condition resulting in death) and Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 110 1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** neg The law requires that the death certificate be executed and

Box 68760,

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of Vital Records,

Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

the

death with

Director

Funeral

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Completed

Be

item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, its "redical Exaction to must be mailined at

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural" or in-any injury or other traumatic event

burial-transi physician sthe burial attending p cate has been signed by the page 2 should be detached the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,

certificate has

Exami Physician/Medical 9 Completed 25. Was case referred to medical examiner? Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 No 9 Unknown

1 | Yes 2 | □ No

29b. Signature and title of certifier

27. Manner of De

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

26. Place of Death (Check onl one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Hesidence 6 Other (Specify,

28c. Injury at Work? 28d. Describe how injury occurred 1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

508 Idlewild Avenue Carolyn Melmly

Easton, MD

DHMH 17 Rev 1/2001

within 2 To the

Registrar

Month, Day, Year)
DEC 0 3 2008 31. Date filed (Month)

5 ☐ Pending investigation

6 ☐ Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 13:40P M Thomas Lee Stinchcomb November 28,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) 1 G M 2 □ F Months Days Hours 219-12-3388 83 Feb. 25,1925 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modeal Examiner must be notified at Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 228 Anchorage Drive 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Tyyes 2 ☐ If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: þ WWII 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson Lee Stinchcomb ပ Emily Edith Gardner 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste F. Stinchcomb/Wife 228 Anchorage Drive, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/1/08 Baltimore, Marvland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha 1 ∐Yes 2 🖵 🌬 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dioc5829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) edical Centr MD Annex 31. Date filed (Month, Day, Year) Registrar's Signature DEC 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:07 Рм November 2008 John Philip Schelin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Health Care Center Prince George's Bowie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) **X**XM 2□ F 55 27, Director 1953 Washington, DC 217**-**56**-**3736 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director XXYes 2 ☐ No Maryland | Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 9802 53rd Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Yes 2**X**No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ YO Specify Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Fire Arms and Elementary/Secondary (0-12) College (1-4or 5+) Retail Business Owner Police Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Louise Nickels ပ Olof Joseph Schelin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16200 Audubon Lane Bowie, MD 20715 Robert Schelin/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/2/2008 | Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 101 Phi 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) arteri disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ 1¶o icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 10 No 1 □Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. 24 hours after deat Funeral Director:

Baltimore, Maryland 21215-0036

Medical within 2 To the I Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jaffe, MD, 7500 Hanover Parkway, Suite 105, Greenbelt, Maryland 31. Date filed (Month, Day, Year)

DEC 0 3 2008

gistrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

6554500Q

29d. Date signed (Month, Day, Year)

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Amended Item 26 per verbal from CHC 12/03/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician E. Simon 0850M 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner arroll Hospita Vestminste arro 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 212-62-3959 Director May 15 1953 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Experience must be nutified at Director 1 ☐ Yes 2 ☐ No Carrol1 MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 636 E. Nicodemus Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian 1 ☐ Yes **2** No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item any Injury or other traumatic event, Item Mones. College (1-4or 5+) Machinist Congoleum 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Beattie Simon Alice Beatrice Walker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Simon/wife 636 E. Nicodemus Road Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deer Park UMC Cemetery 11/29/2008 Smallwood, MD 21. Signature of Funeral Service Pritts Firefall Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myscardic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 □ Yes 2 **Y**No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No Certification: To 2 X ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attent within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Sont DAVID

Registrar
DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year,

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32. Regittrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ernest Julius Swann State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 1, 2008 JULIUS SWANN ERNEST 0622 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Shady Grove Hospital Rockville Montgomery 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Davs Hours Min 215-36-2598 70 Director March 6 1938 Country) Maryland 1 💢 M 2 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Md. Montgomery Germantown Yes 2 X No 28a-f show the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20874 United States 18842 Poppy Seed Lane 23а Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 1 X Yes If Yes, Give Year 1961-1962 White 4 X Divorced 1 Yes 2 No specify: Widowed Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than the Medical MD 21215-0036 Transportation Cab Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Albertina Amelia Gronberg 27 is marked Be George Cornelius Swann ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5113 Iroquois Street, College Park, Md. 20740 Constance D. Breen/Daughter item , 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) F. Burial 2 X Cremation 3 permit. Pages
Department or
Important: I 12/4/08 Alexandria, Va. Metropolitan Crem. Donation 5 Other Specify 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Box 5038, Laytonsville, Md. 20882 0. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed and Physician/Medical UNPENDED AMENDED that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş ے No 3 Probably 4 ✔ Unknown The law requires Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? page certificate ✓ Yes 2 1 V Yes Nο 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this ۵ 1 🗸 Yes After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural Yes 2 No Pending 24 hours after death. To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 10, 2:00 P.M William 2008 Lee Shaw /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 321 N. Third Street 0akland Garrett 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Months Hours Min Yrs. Director 212-36-6624 1939 Maryland Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 N. Third Street 21550 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than \*r any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Shaw Margaret Hackman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Shaw, Wife 321 N. Third Street, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery 12/15/2008 Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Katherine Suestier 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause breach line. Approximate Interval Between Onset and Death Emill. organ Immediate Cause (Final disease or condition resulting in death) **Physician** veordari /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate ! 1 Yes 2 No To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 🗌 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12/10/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, MD 311 N. Fourth St., Oakland, MD 21550 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Betsey Shockley 12 8:42 P 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2/11/1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months 69 Director 182-30-0650 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ant: If item 27 is marked other than "natural" or other traumatic event, Ite Monicol Exp. almar must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 Tyes 2 No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Mystic Harbour Blvd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ingham Etta Gensumer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Shockley 9 Mystic Harbour Blvd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 12/7/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Cardiovascular Disease Physician Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 ☐ Yes 2 MNo 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 2 **X**No 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, To the Hospital within 24 hours a To the Funeral Completely filled

P.O. Box 68760,

Baltimore, Maryland 21215-0036

BA 5

State Registrar 31. Date filed (Month, Day, Year) DEC 0 8 2008

29a. Certifier

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montgomery Phyllis Nichelson mo 18101 Prince Phullip Drive

00028429

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Olney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death. Medical Examiner December 9, 2008 2318 hrs Allen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death-4c. County of Death Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Director Months Days Hours 577-80-2692 1 X M 2 F 50 Country) 30, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No District of Columbia Washington Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5429 Central Avenue, SE 20019 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black White, etc. African Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married 1 X Yes -0 Yes 2 X No specify: Widowed If Yes, Give Year Divorced Specify: American the Medical Examine è 15. Decedent's Education (Specify only highest grade completed) within 72 hours 16a. Decedent's Usual Occupation (Give kind of work done. 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5-0036 2 years Office Mover Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages I and 2 should be filed nent of Health and Mental H int: If item 27 is marked o r other traumatic event. It Fred A. Tate 2121 Be Estelle Simms 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N O Dedra Tate - Wife 5429 Central Avenue, SE Washington, DC 20019 Baltimore, I permit: Pages I and Department of Heath Important: If item injury or other tra 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State incoln Memorial Cemt. Dec 16, 2008 Suitland, MD Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Se Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 23 | Fart I. Enter the 🛰 ease, or complication in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva Pillure. List only one cause on each line. Between Onset and /Medical a. Cocaine intoxication associated with atherosclerotic Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): cardiovascular disease Sequentially list conditions. if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23a,27,28a-f, perME, g886 12/23/08 TT X UNPENDED tending physician use as the burial The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Records, Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✔ Yes 2 No 1 V Yes 2 No 25. Was case referred to medical director, Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DDA Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification Natural Pending Yes 2 XNo To the Funeral Director: completely filled in by the Fd 12/9/08 Fd 10:00 Accident Investigation completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5429 Central Ave. S.E. Washington D.C 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide found residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 10, 2008 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signatu

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

DEC

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Nov. 21, 2008 6:36a Nikita Turin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 543-48-9275 unk. unk. Director China Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 9507 Flower Avenue USA 20901 Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed of Health and Mental Hygiene. I ttem 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Electric Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. unk. မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Potapov/Pastor 4001 17th Street N.W. Washington, D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 Removal from State Department o Important: If any Injury or once, ± 5 Rock Creek Cem. 11/26/2008 Washington, D.C. Other (Specify) 4 □ Donation 21. Signatur of PHILIP ADESRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Necrotizing Fascitis of neck 1 mo. /Medical Due to (or as a consequence of) Examiner Respiratory failure 1mo. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ status post tracheostomy, stratus post 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Be Completed gastrostomy, multiple debridement of neck for 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? /es 2∐No fascitis, anemia certificate 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Yo 1 🔲 Inpatient 2 🛮 ER/Outpatient Certification: To 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🔼 Natural Injury 1 ☐ Yes 2 ☐ No

To the Hospital or AttendIng Physiclan: The law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, n 24 hours after death.

The Funeral Director: A pletely filled in by the fu death. within 24 hou To the Fune completely fi

altimore, Maryland 21215-0036

5 ☐ Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier row du

29c. License number D43121

29d. Date signed (Month, Day, Year) Nov. 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nurul Chowdhury MD 15216 Dino Drive Burtonsville, Md 20866

State Registrar

Medical

31. Date filed (Month, Day, Year) DEC 0 5 2008



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	viti To	2	29b. Signature and title of cert	The HILL			29c. Licens		,	17	signed (Month, $5/08$	
1			30. Name and address of pers	NUES 1 100 FCC	noth /ltom 0	(2a) /Tune	Doo	35653		12	1000	
			0 - Mach	Hostrad	Jam (IIOIII Z	JII	W. Hig.	h 51. S	suite 1	04 81	Kton 1	no 21921
	Sta	te	31. Date filed (Month, Day, Ye	ar) 32. Registra	ar's Signatui	re	<i>M</i> .					
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DHMH 17 Rev 1/2001

		For State Registrar	State o	f Maryla	-	artment of F				giene Reg. No.	008	1	255
Physici	an	1. Decedent's Name (First, Middle					-		2. Date of Dea Month		Year	3. Time of	
/Medio	cal	Catharine		D.		rader			11		2008	13:1	9рм
Examir	ier	4a. Facility Name (If not institution		,		4b. City, Town, or Rocky				4c. County	of Death Come1	~ 17	
Funeral	_	Shady Grove 5. Social Security Number	6. Sex	7. Age (In y	spital rs. last birthday)				8. Date of Birt	h		_	r Foreian
Director		222-16-9902	1□M 2 <b>⊠</b> F	76	Yrs.	Months Days	Hours	Min.	10-30	y, Year) -1932	9. Birthpla Countr	DE	
P .		Usual Residence of Decedent											
aryla shov	<u> </u>	10a. State 10b. County			City, Town or Lo						100	l. Inside Cit 1 1 Yes	-
the M	Director	MD Montg	omery	Ga	aithers	5burg 10f. Zip Code				10 035	1/11 O1-		2 110
with	ä	7552 Augustii	no More			20879				10g. Citizen of	What Country	11	
death	Funeral	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13.		lispanic O	rigin? (Spe	cify Yes or No-	USA 14. Rad	ce - Americar	n Indian.	
or iter		1 ☐ Never Married 2 ☐ Marri	Armed Fo ied 1 ☐ Yes	2 X No		Was Decedent of H			Rican, etc.)		ck, White, etc	D	
Z 1 Z 1 3-0030 d within 72 hours after death with the Marylar glene. sr than "natural", or items 23a or 28a-f show the fredical Exp. oil er must be muffled at the fredical Exp. oil er must be muffled at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Gi Year or D	ve ates:		1 ☐ Yes 2 🔀 No	Specify	/:		Specif	y: blac	!K	
72 h 72 h "natu	Completed	15. Decedent (Specify only highest	's Education st grade completed)		ı (Give	dent's Usual Occup kind of work done	during mos	st of workin	ng i	16b. Kind of B	usiness/Indu	stry	
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R 음주특별		17. Father's Name (First, Middle,			1		18. Moth	ner's Name	(First, Middle,	Maiden Surnan			
yland  Suld be file Mental Hy arked othe attic event	To Be	Chester Was	hington				Co	nsue	lla (D	eal)	,		
Marylanc	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street					State, Zip C	ode)	
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Daltimore, permit. Pages 1 an Department of Heal Important; If item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demousi from	State R	. Place of Dispo	osition (Name of maigree-therplace	e)	Da	ate	20c. Location -	•		
Pag Iment Iment Iury c		4 □ Donation 5 □ Other (Sp				1 Park	1	12/4	/2008	West (	Chest	er, F	PA.
Daltimor permit. Pages Department of Important; if it any injury or o		21. Signature of Funeral Service	dcensee 7			Here Hodes					У		
		By now	WW. (N	MA		.O. Box							
		23a. Part 1. En or the disease, or shock, or neart failure. List of Immediate Cause (Final	only ne cause on e	line.	eath. Do not en	ter the mode of dyin	ng, such as	s cardiac oi	r respiratory ar	rest,	lr C	opproximate Interval Betwonset and D	veen Death
Physician /Medical		disease or condition resulting in death)				eart fai	llure	e					
Examiner			Due to	(or as a cons	equence ot):								
alia .	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury	b. Due to	or as a cons	equence of):								
cuted nd ransit	Examiner	that initiated events	C.										
be exe	Ä	resulting in death) Last	Due to	or as a cons	equence of):								
icate be executed physician and the burial-transit	dical	· ·	d										
Attending Physician: The law requires that the death certific ardeath.  ardeath.  ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, out	come of pred	nancy								
DOX eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	oirth 2  Fe	etal death 3	Ectopic pregnancy Other (specify)	у				te of delivery onth D		ear
the d	ıysi	1 ☐ Yes 2 ☐ <b>X</b> o 9 ☐ Unknown	9 ☐ Unkn		, dod 3 L								
s that	by Pi	Part II. Other significant condition	ns contributing to de	eath but not r	esulting in the u	nderlying cause give	en in Part	l.	23e. Did to	bacco use cont	ribute to the	cause of de	eath?
aw requires the second system of the second signer 2 should be d	ed b	Deep venous	thrombo	sis_					1 □ Y	es 2 □ No	3 ☐ Probab	ıly 4🎦 U	nknown
law re as be 2 shc	plet	cardiomyopa	thy						24a. Was a	an 24b.	Were autops	y findings a	vailable
The The page	Completed	pleural eff	usion						autop: perfor 1 □ Yes	med?	death? 1 🗆 Yes 2		iuse ui
VICIAN: Tician: Tician: Tector, pa	Be (	25. Was case referred to medical examiner?	11					e of Death	(Check only or				
Physical this call dire		1 Yes 2 XNo			☐ ER/Outpatier		4 🗆 10			ence 6 □Oth			
Attending Phy r death. ector: After this by the funeral of	io	27. Manner of Death Natural 5 Pending investig		or injury th, Day, Year)	28b. Time of lajury	Work	yat ⟨? Yes 2□		8d. Describe h	ow injury occurr	ed		
Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At	home, farm, str	eet, factory, office	165 2 🗆		8f. Location (S	treet and Numb	er or Rural F	Route Numb	ner l
d in b	Certification: To	4 ☐ Homicide determi	buildi	ng, etc. '(Spe	cify)	,			City or Tow	n, State)	er or raidir	oute reamb	, ,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral after death.  To the Funeral inferctor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	g Physician: To the	best of my k	nowledge, deat	h occurred at the tin	ne, date a	ınd place, a	and due to the	cause(s) and ma	anner as stat	ed.	
the Horin 24 the Fi	Medical	(Check only 2 Medical E	Examiner: On the band mann	asis of exami ner stated.	nation and/or in	vestigation, in my o	pinion, dea	ath occurre	ed at the time, o	rate and place,	and due to th	e cause(s)	
Veith Veith Com	Σ	29b. Signature and title of certifier	/A LA.4	3 . 5		29c. License				29d. Date signe			
		Madeur		····		000	625	62	N	OVEMB	ER 28	200	78
19		30. Name and address of person w											
Sta	to	Madhavi Hubb 31. Date filed (Month, Day, Year)	) <b>ту</b> 9	901 M egistrar's Sig	edical	center	Dri	ve	Rockvi	lle, I	MD 20	850	
Registra		DEC 0	1 2008	General	, 15 1	Come							

DHMH 17 Rev 1/2001

		•	for State Registrar	State of Ma	aryland /		rtment of F rtificate of	Health and I Death	Mental H	ygier Reg. N		laor	_
	Physici	an l	1. Decedent's Name (First, Middle, La	st)					2. Date of D	Г	Day Year	3. Time of Death	J
	Physici /Medic		James W. Taylor						Decemb	er	3, 2008	9:15 A M	J
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death	1	4	c. County of Death	i .	
4			Suburban Hospita  5. Social Security Number 6. S		a (la una la at	to inch along	Betheso		8. Date of B		Montgomer	2	
	Funeral Director		1		e (In yrs. last 64	Yrs.	Months Days	Hours Min.	May 26	Day, Yea	r) Cou	pplace (State or Foreigi intry) Cyland	n
			219-42-3858 Usual Residence of Decedent						riay 20	, T	744 Mai	yland	_
	rylan show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits	
	e Ma 8a-f s	Director	MD Montgom	ery	Rock	vill	e					1 ∏XYes 2 □ No	'
	vith th		10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Cou	ntry?	
	s 23	eral	800 Lincoln Stre	12. Was Decedent	Ever in U.C.	10.1	2085		if- V N		nited Sta		_
Maryland 21215-0036	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 If Yes, Give Year or Dates:			Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	10-	14. Race - Ameri Black, White, Specify: Wh	ck, White, etc.	
20	72 hor	sted	15. Decedent's Ec (Specify only highest gra	lucation	16	Sa. Deced	lent's Usual Occup	ation	kina	16b.	Kind of Business/Ir	ndustry	_
21	within 7 iene. <b>than "r</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use retired	during most of word d)	King	Me	ontgomery	County	
12	e filed wi al Hygier other th		12			Mecha	anic				ublic Sch	ools	_
anc	be filed ntal Hyg ed other: event,	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nam					
Ž	hould by marked marked matic events	2	Charles W. Taylo:		1,	Ob Mailin	a Address (Street	Mary El			ban vor Town, State, Zi	- 0-4-1	
Z	nd 2 s Ith ar 27 is 1 trau	( )	Barbara A. Taylo:		1			Street Ro				j Codej	
<u>a</u>	f Hea		20a. Method of Disposition	(WITE)			sition (Name of natory or other place	1	Date		Location - City or To	own, State	_
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic es		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				dem. Park	Dec	. 06,	Pa	alesed 1.1 a	MD	
alti	mit. partm porta / Inju		21. Signature of Funeral Service Licer		1 42102			ss of Facility De		era	ckville,	MD	
Ω_	Depa Impo any Ir		IRACH.	rund							urg, MD 2	.0877	
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acch	I the death. D	pain	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	Ì
	Examiner	ier	Sequentially list conditions,	b. See to (or as	a consequence	e off:	brezic	0.0				Untray	+
	nd ransit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Hype	rtens	ois						Unknow	1
68760,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (dr as	a consequenc	e of):		,					
387	physicate sthe	edical		d									
.O. Box (	The law requires that the death certil ate has been signed by the attending bage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal dea		Ectopic pregnanc	у			23d. Date of delive Month	rery Day Year	
rds, P.	w requires that s been signed t should be dete	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resulting	j in the ur	derlying cause giv	en in Part I.			<b>A</b>	the cause of death?	,
ecc	law re las be	Completed							24a. Was		24b. Were auto	opsy findings available empletion of cause of	,
<u>ح</u>	ysician: The last certificate hadirector, page	Son							perf 1 □ Yes	ormed?	death?		
Vita Vita	ilcian: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Linewitzt.			15	26. Place of Dea	th (Check only	one)			_
of	Physician: r this certificaral director, p	ဥ	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 ☐ Inpatie		Outpatien  Time of	t 3 DOA Oth	4 LI Nursing H			6 ☐ Other (Speci	fy)	
e O	ding I h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	28c. Injur Worl	yat ⟨? Yes 2 □No	28d. Describe	how inji	ury occurred		
Division of Vital Records,	or Attending after death. Director: Afte in by the fune	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At home, c. (Specify)	farm, stre		163 2 110	28f. Location City or To	(Street a	and Number or Run te)	al Route Number,	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one)  Certifying Principle (Check only one)	ysician: To the best niner: On the basis o and manner sta	f examination	lge, death and/or inv	occurred at the til restigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time	e cause , date a	(s) and manner as : nd place, and due t	stated. o the cause(s)	
	To the within 2 comple	Me	29b. Signature and title of certifier	Somes	MI	)	29c. Licens	e number 6299 S	3		ate signed (Month,	Day, Year) 03 200	8
			30. Name and address of person who				·	_					
			Petek Donmez M.D 31. Date filed (Month, Day, Year)		ckvill ar's Signature	e Pil	ke Rockvi	lle, MD	20852				_
	Sta Registra		DEC 0 5 200		a s Signature	Shop	the same						
DUI			DEC 0 9 200	June 14	, ,,,	7							_

DHMH 17 Rev 1/2001

Taylor, James 12/3/08 9:15AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0204 M 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 336 Hamlet Circle Edgewater Anne Arundel 9. Birthplace (State or Foreign Country)

New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/9/1933 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 131-26-7523 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes 2 🛣 No Directo Maryland Anne Arundel Edgewater 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 Hamlet Circle 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 ∏Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill the and Mental H 7 is marked ott Be Frank Lucente, Sr. Maria Aragona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any Injury or other traum Gerard F. Vricella/ Husband 336 Hamlet Circle, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/5/08 Clinton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Annal 22. Name and Address of Facility George P. Kalas Funeral Home Milleulle 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events) Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 □Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. The Funeral Director: After to 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2 29b. Signature and title of certific 29c. License number

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 3

32. Figistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature April

			State of Maryland / State of Maryland / Registrar	Department of He Certificate of De		giene Reg. No. 🤈 🔒 🕦	o lhora
	Physicia		1. Decedent's Name (First, Middle, Last) Dorothy Washington		2. Date of Do Novemb	eath	3. Time of Death
)	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  Genesis Elder Care   Spa Cre  5. Social Security Number  220-24-4504  Spa Cre  1 □ M 2 ▼ F  87	irthday) If Under 1 Year   II	lis FUnder 24 Hrs.   8. Date of Bi	4c. County of De Anne Ar	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madeal Eyminier must be notified at once.	tor		vn or Location			10d. Inside City Limits
		al Directo	10e. Street and Number 1811 Bowman Dr.	10f. Zip Code 21401		10g. Citizen of What C	Country?
		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Novidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	14. Race - Am Black, Wh Specify:	ite, etc.
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 7th 0	a. Decedent's Usual Occupatic (Give kind of work done duri life. DO NOT use retired) Domestic	on ing most of working	16b. Kind of Business Private	
		To Be C	17. Father's Name (First, Middle, Last)  John Martin		3. Mother's Name (First, Middle Mamie Falcon		*
			19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Vanessa Washington(Daughter) 1423 Tyler Ave Annapolis, Md. 21403				
			20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. H Red Concept of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel of Cemel	lumes tvame of ery, crematory or other place) rial Gardens	· · · · · · · · · · · · · · · · · · ·	20c. Location - City of Annapoli	s, Md.
Ball			21. Signature of Funeral Service Licensee	821 West	of &o⊪Sons Mort St. Annapoli	s, Md. 21	401
	To the Hospital or Attending Physician: The law requires that the death certificate be executed by within L2 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or in the funeral director.	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
P.O. Box 68760,			d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Pro 9 □ Unknown  d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of d Month	elivery Day Year
rds, P.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown				
Division of Vital Records,					24a. Was auto perf 1 ∐Yes		
			25. Was case referred to medical examiner?  1				
			Med	one) and manner stated.  29b. Signature and title of certifier	29c. License n		29d. Date signed (Mon
		Kahr	7	30. Name and address of person who completed cause of death (Item 23a)	) (Type, Print)	136	12/2/s
	Sta		31. Date filed (Month, Day, Year) DEC 0 3 2008  32: Registrar's Signature	Di Davelo 1	some Chy	11/100	46/
	Registr	ar	DEC U 3 2000 Julians	BOOKE !			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Olevia Ellon Watts 5 2008 December 8:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Berlin Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7/8/1920 5. Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2**X**□ F Months 88 MD 222-01-7767 Director Usual Residence of Decedent 10d. Inside City Limits Show 10a, State 10h County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or items 23a or 28a-1 sho Injury or other traumatic event, It e Medical Examinat must be notified at 1 ☐ Yes 2X ☐ No Director Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 17 Burley St. Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Completed by Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "ns any Injury or other traumatic event, Its Medits once. Elementary/Secondary (0-12) College (1-4or 5+) Hotel Maid Hotel 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katie Layton Hurdle Mitchell ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Jester / daughter 17 Burley St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/8/2008 New Hope Cemetery WIllards, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Fundal Service Licensee 108 William St., Berlin, MD 21811 mela 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCUEDO T /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine burlal-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the burla requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lonknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 □Yes 2 1000 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury occurred Certification: al or Attending F safter death. I Director: After of in by the funera 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

BA5

Watts, Olivia

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

32. Registrar's Signature

614

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:40 am December 03 2008 Saralyn Wolff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2図F Yrs. Director 439-10-1814 96 July 31, 1912 Louisiana Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 K No Rockville Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Landow House, 1799 East Jefferson Street 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. , or Items Black, White, etc. e filed within 72 hours after all Hygiene.

A Hygiene.

other than "natural", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Statistician United States Government 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 David Vilensky Blume Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Veazey Terrace, NW, Washington, DC 20008 Elliot Wolff - Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Adas Israel Congregation 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 12/05/2008 Washington, D.C. Cemetery 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Pa(1. Enter) he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by the Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 2[] No 1 Yes 2 🖾 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☑ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 🖾 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗌 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D66304 December 3, 2008 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Sujoy Ghosh Tagore, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) Registrar's Signature Registrar DEC 0 5 2008

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended#8perFH FCHD KS 11/4/Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26 2008 3:30 P William M Ziegler 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 214-52-3458 53 Sept. 25, 1955 Maryland Usual Residence of Decedent Sept 22,1955 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Frederick Middletown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21769 2401 Tabor Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📆 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Computer Programer I.T. Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ziegler Lillian Koch John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shurleen C. Ziegler / Wife 2401 Tabor Dr./ Middletown, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) I 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 12/03/2008 Rockville, Maryland Parklawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Intra disease or condition resulting in death) Crania Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

/Medical Examiner ng physician and as the burial-transit certificate be execute P.O. Box 68760, use ģ signed by t d be detach Division of Vital Records, has page 2 s Physician:

Physician

Examiner Physician/Medical Completed by this certificate Be Certification: To completely filled in by the funeral al or Attending F s after death. I Director: After After within 24 hours a Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If flean 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Modest Exp. Inc. 1181 be retified any injury to other traumatic event, it is Modest Exp. Inc. 1181 be retified a

Baltimore, Maryland 21215-0036

								autopsy performed? 1 ☐ Yes 2 ☑ No		ompletion of cause of
25. Was case referred to	medical					26.	Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 Inpatient	spital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
2 Accident	☐ Pending investigation			Fime of njury M	i	Injury at Work? 1 □Yes		8d. Describe how injury	occurred	
3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not be determined		- At home, fa (Specify)	rm, street, fa	ctory, off	fice	2	8f. Location (Street and City or Town, State)	Number or Ru	ral Route Number,
		nysician: To the best of miner: On the basis of e	xamination ar							

ture and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

11-28-08 D60417

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shal Frederica 65C Thomas Year) 0 2 Day, 31. Date filed (Month.

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Fevin 1010 OVIC 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1⊠M 2□F 60 Director 507-68-5068 January 7, 1948 District of Columbi Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Explainment is a followed at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2445 Lyttonsville Road, Apt. #214 20910 ILS.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No 2 If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Montgomery County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Albert Zevin Bonnie Ruth Nathanson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Zevin - Father 2701 Spencer Road, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden's 12/05/2008 Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licentee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal Failure /Medical Due to (or as a consequence of): Examiner Pancreatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed burial-tra P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, *o*utcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> icate has been significate has been significated by page 2 should by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate performed' 1 □Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Nation 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural death. To the Hospital or Attendi
) within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 8

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 5 2008

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32. Zgistrar's Signature

se of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814

08-09217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of I fille it bia	01/ 11/0/01/01/01/01/11	
State of Maryland / I	Department of He	ealth and Mental Hygiene

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Physicia		egistra: 2. Date of Death 3. Time of Death 3. Time of Death	7
ledical Exami	ner	William Alston December 8, 2008 1237 IIIS	<u>.</u>
	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  701 Arlington Avenue Apt. # 503  Baltimore	
		To Ace (leaves lest highers) Let Linder 1 Year Let Linder 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	
Funeral Director		5. Social Security Number 6. Sex 7. Age (III.yts. less birdingly) Months Days Hours Min. March 15,1925 Country Carolina	
	K	Have Decidence of Decedent	
any		10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No.	- 1
faryland 28a-f show Lat once.	5	Ma. NA Baltimore Itos Citizan of What Country	
Mary r 28a- ed at	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Coultry?	1
ith the 23a or		11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	-
ath w items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Never Married 2 Married 12. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. White, etc.	
frer de		Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:	
1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	ed be	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
36 in 72 h han "r lical E	Completed	12 College (1-4 or 5+) Merchant Seaman U.S. Coast Guard	1
5-0036 iled within 7 Hygiene.	Ë	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medical		Tames Major Alston Della Brown	-
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be riviffed at once	유	19a. Informant's Name/Relationship (Ty., Print grandday) ten 558 W. Preston St. Butto Ma. 2120	, T
M 2 alch		20a. Method of Disposition Date 20c. Location - City or Town, State	-
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Itimo		4   Donation 5   Other Specify:   22   Name and Address of Fig. 19	7
Balti permit. Departu Import		Joseph Likuss runeral Tome, M. 21216	
Physician		Approximate Intervention 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset are failure. List only one cause on each line.  Death	
'Medical aminer		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	-
		or condition resulting in death)  Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate Oue to for as a consequence of:	
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uted uted Id	Ä	events resulting in death) Last Due to (or as a consequence of).	-
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ox 68760, eath certificate be est attending physiciar for use as the burial for use as the burial	Me.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year	
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Box 687  c death certification attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death?	$\dashv$
; P.O. Beires that the designed by the			'n
S, P puires 1 en sign	ed	Emphysema 24a. Was an 24b. Were autopsy findings availa	ble
cord aw rec nas bee 2 shou	et	autopsy prior to completion of cause of death?  per or which is a substitution of cause of death?	זג
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of V ing Phys After thi	1.1	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
OD ( cendin sath.	j	1 V Natural 5 Pending 2 Accident Investigation (Street and Number of Rural Route Number.)	200
VISI or Att of Att of Att of Att	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Court or Town, State)	ıty
Spital Spital hours a	Se	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and comminderly filled in whe funeral director, page 2 should be detached for use as the burial - transity.	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
Tour	Med	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)	
		O.C.M.E. December 9, 2008	
2		30. Name and address of person who completed cause of death (Item 23a)	
)		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Reg	State stra		
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# Baltimore, Maryland 21215-0036

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, P.O. Box 68760, <sup>(K)</sup>	that the death certificate be executed	ned by the attending physician and detached for use as the burial-transit
Division of Vital Records, P.O. Box 68760, 🌣	i or Attending Physician: The law requires that the death certificate be executed after clearly	Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit

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Physicia	an	Decedent's Name (First, Middle, Last)  2. Date of Death Month Day							Day	Year	3. Time of Death			
/Medic Examin	al er	Andrew Amtmanr  4a. Facility Name (If not institution, give street and number)						Location of Death	December	r 19, 2008   12:00p M 4c. County of Death				
5		Ivy Hall  5. Social Security N		ric & Rehab		last birthday)	Middl If Under 1 Year	8. Date of Birth		ltimor	Ce place (State or Foreign			
Funeral Director								8. Date of Birth (Month, Day August 15	5, 1923 Maryland					
yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									1	0d. Inside City Limits		
the Mar 28a-f s	Director	Maryland Baltimore Dundalk  10e. Street and Number 10f. Zip Code								Inc. Citizen o	1 ☐ Yes 2 XNo			
th with 23a or	al Dii	7 Midway	Tibel				2122	2		USA				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 【X Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 【XYes 2 □ If Yes, Give Year or Dates:			? ] No	S. 13.	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Whit	etc.			
72 hou "natura dieni E	eted	15. Decedent's Education (Specify only highest grade completed)				(Give	dent's Usual Occup kind of work done of	during most of work	ing	16b. Kind of	Business/Inc	dustry		
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be filed ntal Hys ed othe event,	Be	17. Father's Name (							e (First, Middle, Maiden Surname)					
should and Mei s mark« umatic	욘	Andrew F. Amtmann  19a. Informant's Name/Relationship (Type. Print)					ng Address (Street			e M. Butterhoff  Route Number, City or Town, State, Zip Code)				
l and 2 Health a mm 27 is		Susan Han		Daughte				Avenue, Es	· ·					
Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disp 1 X Burial 2 Donation	☐ Cremation	3 ☐ Removal from State pecify)		cemetery, crei	osition (Name of matory or other place OF <b>Jesus</b> (	December 23,	ber	20c. Location  Dundal				
permit. Departi Import any inj		21 Signature of Fu	22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222											
Physician /Medical Examiner ial-transit	Examiner	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Interval Between Onset Inter												
eath certificate be attending physicia for use as the bur	Physician/Medical Ex	The sellting in death) Last  Due to (or as a consequence of):  DEPRESIDM.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Unknown  1 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Ectopic pregnancy 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Month									ate of deliver	ery Day Year		
w requires that the dispension is been signed by the should be detached	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco us								bacco use co	ntribute to th			
n: The law requificate has beer or, page 2 shou	e Completed	25. Was case referi	red to medical					26. Place of Deatl		med?	. Were auto prior to co death? 1 □Yes	psy findings available mpletion of cause of		
hysicia his cer al direct	00	examiner? 1 ☐ Yes 2 ₽		Hospital: 1 ☐ Inpa		ER/Outpatie		er: 4 Nursing Ho		ence 6 🗆 O	ther (Specit	(y)		
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Deatl  1	h 5 ☐ Pendin investiç 6 ☐ Could ı determ	gation not be 28e. Place of li	ay, Year)	28b. Time o Injury ome, farm, str	Work	Yes 2□No	28d. Describe ho 28f. Location (St City or Town	treet and Nun		al Route Number,		
e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier (Check only one)		ng Physician: To the bes Examiner: On the basis and manners	of examina									
To th within To th comp	Σ	29b. Signature and		r		e MI	29c. Licens			/2 -				
1		Sanual (Talla M) D27188 12-19-08  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sanual (I Julia 2 Market Place Dundali M) 2/222  31. Date filed (Month, Day, Year)  32. Registrar's Signature									2/222			
Sta Registr		31. Date filed (Moni		39	iai s Gigila	Moorte.	ŝ							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1620 PM **Physician** DEC vesl rrinaton 2008 /Medical 4a. Facility Name (If no institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign , Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2□F 241-62-5323 Usual Residence of Decedent North Carolina Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If then 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Im. Mydical Expriser, just the state once. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 XYes 2 □ No Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? ourne Was Decedent Ever in U.S. Armed Forcas?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18! Mother's Name (First, Middle, Maiden Surname) Be 2 ula -00 19b. Mailing Address (Street and Number or Rural Route Number, City or To , State, Zip Code) 19a. Informant's Na Te/Relationship (Type. \*\* t) (Fiancee) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave Bulto. N 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTRIC UPPER BLEED **Physician** DA YI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COLON METALTATIC YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit ACCITTES MONTHS Due to (or as a consequence of) 68760, Completed by Physician/Medical PLEURALEFFULION MONTHS Box ( IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 □Yes 1 ☐ Yes 2 X No Vital 2 X No or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Npatient Medical Certification: To o After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death

1 Natural

2 Accident 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies DAddicker

Registrar DHMH 17 Rev 1/2001

State

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RKING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DURGA DIOT 31. Date filed (Month, Day, Year)

DEC 2 2 2008

MOHIKARI

32. Registrar's Signature

P23612

900 CATON AVENUE BALTIMORE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, give stree 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home 9. Birthplace (State or Foreign Country) Date of Birth **Funeral** 9-26-1919 1 M 2 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at 1 des 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be eaver.bi Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. ndary (0-12) College (1-4or 5+) 1to.C1k marked other 17 Father's (First Middle Last 18 Mother's Name (First Middle ages 1 and 2 should be fill nt of Health and Mental H: If item 27 is marked oth 19a. Informant's Name Belationship 19b. Mailing Address (Street and i mber or Rural Route Numb brookRd 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Important: 21. Signature of Puneral Service Licensee NO 155, Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chrone Farly **Physician** /Medical Due to (or as a consequence of) **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the dor use as the bunal-trans Due to (or as a consequence of) P.O. Box 68760 echni Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐No 9□Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \( \subseteq No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 2

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHVA113 A. HASHMI, & 20 N. ENTAW ST STULE 300 BALTIMOILE MD

MD

32. Registrar's Signature

29c. License number

D31464

29d. Date signed (Month, Day, Year)

12/15/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22perFH, G886, 12/24/08 WS
State of Maryland 7 Department of Health and Mental Hygiene 1 - For Stata Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 16, 2008 **Physician** 1:03 PM M Robert Addicks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Canton Harbor 8. Date of Birth (Month, Day, Year) Jan 17, 1939 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F 69 Director 213-36-1561 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral, or items 23a or 28a-f show Everying hunsi be notified at 1 Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13B Valley Arber Court 21221 USA death v Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter amy injury or other traumatic event, the Medical Ever of any any joury or other traumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk driver transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George William Addicks Lillian Parsons 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 Rosewick Avenue Baltimore, MD Linda Addicks/sister in law 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 1. Signature of Europea Screen Service Size of Pastures Balto. Md. 21286

22. Name and Address of Facility Cafa/Stephen D. Lohrman PA Ronald S. Wade, Director 8712 Green Pastures Dr. Balto. Md. 21286 21. Signature of Euneral Service Licensee Ronald Services wade, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** (brokovnusla & coidents 4000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Arteuralike Cornary Janualin Desur Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1) Jaketes certificate 2 0 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Designer to Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours a To the Funeral C

29c. License number 29b. Signature and title of certified weekens 019667 of erceasel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 12-16-2008

Octivie History # 508 Gleu Borney Tany land 2006/ Hustan ( durans 7310

1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

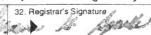
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

cai

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) DEC 2 2 2008



and manner stated.

mend #5, per Fh 9887 1.21.09 TT lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend stem 29d per doc 9886 12-22-08 xtd Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** December ib 0035 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ST. Arres Hos 5. Social Security Number 3565 PHAC BACTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Min. (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 216-34-<del>3565</del> Usual Residence of Decedent Director and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. 10b. County th and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Funeral Director 1 Nes 2 No ti more 10e. Street and Nunioe 10f. Zip Code 10g. Citizen of What Country? 21216 USA ondawm:n 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Degedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry e kind of work done during DO NOT use retired) most of working Elementary/Secondary (0-12) Golege (1-4or 5+) 17. Father's Name (First, Middle, Last) Nother's Name (First Be 2 Howard Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or State, Zip Code) item 27 i permit. Pages 1 a Department of He Place of Disposition Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any Injury or o once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, mD 12.20.08 1500 @ Bity Greene Funeral Services 21. Signature of Funeral Service Licensee 22. N. d 7 n. Ad vati 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure Kespirastory 4 hours /Medical Due to (or as a consequence of): Examiner Vena Cava Syndrome Superior UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed STAGE L'UNG Cancer UNKNOWN physician and the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) funeral director, page 2 should be detached 9 Hlnknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ...
autopsy
performed?
Yes 2 ANo has After this certificate 1 □ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12-16-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Baltimore aton 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** COLUMBUS BROWN JR. Decembe 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Squale
5. Social Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Security Number | 6. Secu BO / FIN O / P 9. Birthplace (State or Foreign Country) rdale ear | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) XXM 2□ F Months Days Hours Min. MARCH 17 1936 219-32-6830 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XXNo MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1610 BROWNS RD. 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ★XXYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. MXYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 ZNo Specify. ģ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade POSTAL CARRIER U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COLUMBUS BROWN SR. ဥ HELEN GARDNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Brown/Wife 1610 Browns Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 12-19-08 BALTIMORE, MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Develle 1206 W NORTH AVENUE 23a. Palt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nemia Due to (or as a consequence of): gastroin Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ulcer Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Multiple 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy resction cancer perform 25. Was case referred to medical examiner? IP radiation Prostate cancer 1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

certificate be executed Box 68760, P.0. Division of Vital Records, the Hospital or Attending Funeral

Director

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?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examination of the retified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ite Ma

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To the Funeral Director: A

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Pages 1 and 2 should

Baltimore, Maryland 21215-0036

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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Dr. Sa Fal

31. Date filed (Month, Day, Year)

Kesoood

Franklin Square Drive Baltimore MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Raven **Funeral** BOY, Varnice Hours 1 □ M 2 1 F Months Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 211 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify 3 ☐ Widowed 4 ☐ Divorced lack 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Johns boses and Mental Hygiss is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ပ္ 19a. Informant's Name/Relationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. iccle mmon 20b. Place of Disposition cemetery, crematory Pages ' 1 ☐ Burial 2 【Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee runeral Home W. North 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Yea 5 Other (specify) been signed by the s should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☑ No 24a. Was an autopsy performed? Yes 2/2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 4 X Nursing Home 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No hours after death. uneral Director: A the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 9 52 tunger 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Lieselotte H. Bieber **Physician** 3:30 P M December 18, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bonnie Blink Nursing Center Cockeysville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 30, 1914 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√√ 94 218-36-1113 Germany **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Baltimore Cockeysville 1 □ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 300 International Circle 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. m 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 □ Yes 2 **X** X Specify: White Completed by 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Seams LYCL's retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacuring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josef Krause Anna Emilie Klara ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marlies Fisher (Daughter) 13 Jonathan Court Cockeysville, MD 21030 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H
Important: If ite
any injury or ot Woodlawn Cemetery XX Burial 2 Cremation 3 Removal from State 12/22/2008 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice Burgee-Henss-Seitz Funeral Home Inc. 3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Corebro vascular **Physician** 10cers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒️No page 2 s autopsy perform 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

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2121

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar

State

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3208

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

12-18-08

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland /	Department of Health and M	Mental Hygien	e 2008 LDR73
			Registrar		Certificate of Death	Reg. No.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)	19		Month Da	ay Year ///O
	/Medic Examin		A. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	PRECEMBER 1	3 2008 4 77W
		er	GOOD SAMINGITAN 1	VUISING CENTER	- Baltimore CTY	13	Altimore City
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		2\5-28-2793 1 Usual Residence of Decedent	14	Yrs.	1.5.193	a MI
	land ow		10a. State 10b. County	10c. City, To	wn or Location		10d. tnside City Limits
	Mary	to	WD	Ba	Himore		≱⊡¥es 2 □No
	or 28s	Director	10e. Street and Number	. ()	10f. Zip Code	10g. C	itizen of What Country?
	eth wi			th Street	21218		U.S.A
	er de itema	Funerai	11. Marital Status  1 □ Never Married 2 ■ Married	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> <li>Yes 2 □ No</li> </ol>	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
39	urs aft	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occupation (Give kind of work done during most of won		Kind of Business/Industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		10000
7	iled w dygier ther th		17. Father's Name (First, Middle, Last)	2415	18 Mother's Nam	ne (First, Middle, Maide	n Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelin and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show sny lighty or other traumatic avant, the Marical Examinar motal be notified at ance.	To Be	Jerome Bo	atson		arian	Myers
ary	2 should and Men is marke aumatic	۲	19a. Informant's Name/Relationship (Type	pe, Print)	9b. Mailing Address (Street and Number or Ru		
	1 and 2 Heelth a am 27 lu ther tra		Reginald B	sennett	1831 E. 30th St	. Baltimo	16 WM 31318
Baltimore,	Pages 1. nent of He ant: if its ary or oth		20a. Method of Disposition 1/□Burial 2 □ Cremation 3 □ Re	emoval from State	of Disposition (Name of tery, crematory or other place)		Location - City or Town, State
Ē	permit. Pages Department of Important: if i any injury or once.		4 □ Donation 5 □ Other (Specify)	Gan	rison Forest 12-1	4.200	ere Funeriuserices
Ba	permit. Departr Imports eny inju		21. Signature of Funeral Service License	60000	4905 York Ad Bo	ugna core	MD 21717
		H	23a. Part1. Enter the disease, or complic	cations that caused the death. De	o not enter the mode of dying, such as cardiac		Approximate
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final		ED DEMENTUR		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence			
	Examiner		Sequentially list conditions, b				
	De W IIs	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury	Due to (or as a consequenc	e of):		
	al-trar	xan	that initiated events cresulting in death) Last	Due to (or as a consequenc	e of):		
8760,	cate be executed  physician and the burial-transit	dical E	٥				
68	rtiticat ng phy as th		IE EENINE				
Вох	eath certiti ettending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea			23d. Date of delivery  Month Day Year
0	that the death certition of the by the ettending of detached for use as	by Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		West Say
P.O.	res that the signed by be detact	/ Ph	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Division of Vital Records,	quires n sign	q p	RENAZ	FAILURE		1 ☐ Yes 2	2 ☑No 3 ☐ Probably 4 ☐ Unknown
000	aw requir s been si 2 should	piete				24a. Was an	24b. Were autopsy findings available
Ĕ	The I	Completed				autopsy performed? 1 ☐ Yes 2 ☐ N	prior to completion of cause of death?  o 1 ☐ Yes 2 ☐ No
/ita	clan: ertific actor,	Be	25. Was case referred to medical examiner?			th (Check only one)	
<del>_</del>	Physi this c el dire	To.	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/0 28a. Date of Injury 28b		ome 5 Residence	
O	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ary occurred
<u>Visi</u>	Atten r deal sctor:	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home,			and Number or Rural Route Number,
á	s ette	Certification;	4   Hornicide	building, etc. (Specify)		City or Town, Sta.	(6)
	To the Hospitel or Attending Physician: The law requires that the death certilicate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the ettending physician and incompletely filled in by the funeral director, page 2 should be detached tor use as the burial-transit		(Check only 2 Medical Examin	nar: On the basis of examination a	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause(	s) and manner as stated.  nd place, and due to the cause(s)
	thin 2- the f	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, Day, Year)
	₹ <u>₹ ₹ 8</u>		· ()	Kin Ania	4		ENBER, 17, 2008
	1D		30. Name and address of person who co	mpleted cause of death (Item 23a	a) (Type, Print)	DEC	ENDERLITIZUS
_	( )		LORRAINE OF SP	-ANUAM. SYBO	CAMPBELL BLUD ST.	= 214, NOT	T. NGH AM MD 21236
	Sta Regist		31. Date filed (Month, Day, Year)	32. Figistrar's Signature	CAMPBELL BLUD ST		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For amend #5 Per State Registrar	State 88 Mary A		Hattment of F		Mental Hy	giene Reg. No.	008	49374
	Physici	an	1. Decedent's Name (First, Middle, Last)	440				2. Date of De Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	4b. City, Town, o	r Location of Dea	12	4c. Co	Sunty of Death	11.151		
	Examir	ier	Fithere Care	siloot and mamboly		Balt	HMOre		,0.00	July of Dodan	
Į.	Funeral Director		5. Social Security NumbelInk 6. Security NumbelInk	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month Da	rth ay, Year)	9. Birthp Cour	place (State or Foreign ntry)
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow digal Examinations be mailiad at	tor	Cim		Balti	more					1⊕Yes 2□No
	ith the Ma or 28a-f	Funeral Director	10e. Street and Number	•		10f. Zip Code			10g. Citize	n of What Cour	ntry?
	ath wi	ral	161 M. Potomo			2122	4		U	<u>·S. A</u>	•
	Items Items	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	J.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No orto Rican, etc.)	D- 14.	Race - Americ Black, White,	
5-0036	hours after tural', or Ite	by	3 Widowed 4 Doworced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Sį	pecify:	Uhite
5-0	n 72 hours "natural', olcal Ex	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup	during most of w	orking	16b. Kind	of Business/Inc	dustry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	make		ì	Priva	<i>te</i> .
ld 21	illed Hygi othar ant, I	Be Co	17. Father's Name (First, Middle, Last)			Moline		ame (First, Middle	, Maiden Su		2, 0
/lan	2 should be and Mental is marked o	To B	Tracey Be	dsworth			Mar	garet	Ku	hN	
Maryland	2 sh and ia m		19a. Informant's Name/Relationship (Ty	15	19b. Maili	ng Address (Street	and Number or F	250			Code)
	s 1 and f Health itam 27 other tr		20a. Method of Disposition	a / Daughter	Place of Dispo	osition (Name of	mac St	Bathim	ore, 1	tion - City or To	aa9 wn State
altimore,	permit. Pages 1 Department of F Important: If ita any injury or ot once.		1 ☐ Burial 2 ☐ Femation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	matory or other plac	1 151	22 /2mg		Hi more	
alti			21. Signature of Funeral Service License		<b>200000</b>	AT LYCANO  Name and Addre		augho C.			a Services
ä	Per la la la la la la la la la la la la la		Vauchn C	. Meene	L	1905 York	Ad Ba	Hmore	- Mi	Sala	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat ne cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	Hypertanin A	rtems	coneste Co	seming U	Huelas I	Sea	e ·	Onset and Death
	/Medical Examiner			Due to (or as a consec							
	=12/ =	ner	Sequentially list conditions, farm, heading to him solutions cause. Enter Underlying Cause (Disease or injury								
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	)						_	
8760,	ate be execu hysician and he burial-tra		resulting in deathy East	Due to (or as a consec	quence of):						
687	lys er	Physician/Medical		1							
Вох	n certii anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		7			230	d. Date of delive	iry
-	that the death certifica ed by the attending ph detached for use as th	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			i	Month	Day Year
P.O.	d by the	Phys	9 Unknown					00 - Did.			
	Se un e	l by	Part II. Other significant conditions cor	tributing to death but not res	suiting in the u	nderlying cause giv	en in Part I.		obacco use Yes 2□N		ably 4 Winknown
Records,	> Q 10	letec	Dance					24a. Was			psy findings available
Re	e las has	Completed by	Delicerta					autor perfo	psy prmed?	prior to cor death?	npletion of cause of
Vital	vician: Th certificate rector, pag	a	25. Was case referred to medical	creace			26. Place of De	1 ☐ Yes eath (Check only o	2 □ M6   one)	1 🗆 Yes	2□ No
of V	S S D	To B	examiner? 1 Yes 2 No	lospital: 1  Inpatient 2	ER/Outpatier	nt 3 DOA Oth	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Home 5 Resi		Other (Specify	')
0 1	ing PI		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury o	ccurred	
Division	Attanding r death. actor: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	280 Place of Injury - At h	ama farm at		Yes 2 No	28f Location /	Street and A	lumbar or Rum	l Route Number,
Div	l or A after Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, rarm, str fy)	eet, ractory, office		City or To		<i>rumber or Hur</i> a	i Houte Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funaral	edical C	29a. Certifier 1 Dertifying Physical Check only one) 2 Medical Examin	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death ation and/or in	h occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) an date and pla	d manner as st ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	igned (Month, I	Day, Year)
			Turned Con	Cura			9667			6-200	
	1		30. Name and address of person who co		т 23а) (Туре,	Print	CD801	Briver 1	Mani-	1 2 2011	
	Sta	to	1. Date filed (Month, Day, Year)	32 Registrar's Signa	TCLUL \	H marco	303 GU	1 334 CEL	(cur) ku	-(1 2 (0 12)	
	Registr		DEC 2 2 200	18	K da	31/2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mae 18,2008 9:30 AM CRR Ecember /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, gife street and number) 4c. County of Death **Examiner** Haith Kehab Itimore a Hts If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 □ F Months 212-22-794 reorgia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location ... 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** altimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🎶 🕯 🕉 🕹 Norther Pkuy: Balto, md. Bm <u> Jimmu</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Service red HILI 23a. P 11. Poer the disease, or complications that caused the death. Do not enter the mo Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest. Immediate ause (Final disease) r condition resulting in death) **Physician** /Medical Due to (or as a on equence of): Examiner Sequentially list conditions, it may be cause in the following cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 No 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1.2

Registrar

State

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST. Baltimore MD

32. Registrar's Signature

821 N'Eclaro

31. Date filed (Month, Day, Year)

DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** December 2008 5:05 PM™ Beatrice L. Butler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Med Ctr Rel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 3, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 87 1921 Director 064-14-9659 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2√☐ No Important; If item 27 Is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified Director Harford Edgewood MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1614 Swallow Crest Drive #D 21040 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 housewife own home and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abram Masker Pheobe Marie Degroat ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Francis W. Butler/son 808 Sleepy Hollow Court Edgewood, MD Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Vicen Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician herla /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital within 24 hours at To the Funeral D

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

anue

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

29c. License number

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year **Physician** 20 3:44 2 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1**X** M 2 ☐ F 215-86-5489 Director 32 2 15 MD Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas pepartment of Heath and Mental Hygiene. B. Tiff it from 23 aro 28a-f show Important; if from 27 is marked other than "natural", or items 23a or 28a-f show any injunt; if item 27 is marked other than "natural", or items 23a or 28a-f show any injunt; or other traumatic event, it at health 25 are injunts to or other than 25 are in the continual and injunts. Director 1 √Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2471 West Coldspring Lane 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify <u>ک</u> Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bonsal American Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Drive Truck Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Robert L. Collins Sr. Agnes Capel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 2471 West Cold Spring Lane, Baltimore, Agnes Campbell-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 12/20/08 King Woodlawn, Md 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate v ause (Final sudde Physician Cardia Julsele disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 290,00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ~d tag that initiated events burial-tra resulting in death) Last Due to (or as a consequence of physician the burial Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy Parlansi 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

Physician; The law requires that the death certificate be executed Division of Vital Records, certificate has this After or Attending death hours after death uneral Director; Hospital

Box 68760,

P.0.

Baltimore, Maryland 21215-0036

Pages 1

24 hours a completely within 2 the

State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

ZUN 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

560

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Lech

29c. License number

4 pm

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 9:28 PM December 8008 Campbell 16 Michele /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAL Hospital of Baltinone Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 51 MD Director 07 217-70-3617 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the involcal Examiner must be notified at 1 Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3323 Woodlawn Ave by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Macy's Salesperson 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H Mary Johnson Walter B. Campbell ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once. Rebquah M. Brooks-Daughter 5108 Williston Street, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 tment of I 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 12/22/08 Baltimore, Md 21. Signature of Fundal Service higensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erebrai Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner the to come a nonsequence of: Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ng physician and as the burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month signed by the a d be detached fo 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 s performed? autopsy 1 Tyes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Hospital: pital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
(Nonth, Day, Year) Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 16, 2008 Res- 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospidai of Baltimoiza SINAL NAVID MD NOUR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 2 2 Registrar OBS.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Nora Carter Dec 12, 2008 6:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Hamilton Center N/A If Under 1 Year | If Under 24 Hrs. 6 50 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ ₹ Director 217-38-4306 Jul 12, 1936 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1603 East Eager Street 21205 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ≥ 3 □ Widowed 4 □ Divorced Black Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Will Brandford Ella Isaac ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Carter 1603 East Eager Street Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Byorial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 12/20/0B Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Pervice Limins 22. Name and Address of Facility Estep Brothers Funeral Service. P 1300 Eutaw Place Baltimore, Md 21217 le of dying, such as cardiac or respiratory arrest. Do not enter the mode of dy 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner SCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): O. Box 68760, Physician/Medical for use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by should be detac ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has The perform Vital 1□ Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA Certification: To 1 | Inpatient ivision or After this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attend s after death. filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name address of person who completed cause of death (Item 23a) Type. Print Waltham SOPPIN 31. Date filed (Month, Day, 32 Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 00	epartment of Health and M Certificate of Death	lental Hygle <sub>Reg.</sub>	2000
	Physici /Medic		Decedent's Name (First, Middle, Last)     LILLIAN EVA CONAWA	.Y	2. Date of Death Month DECEMBER	Day Year 3. Time of Death 11:30A M
Marine Service	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	DECEMBER	4c. County of Death
أهماري			8911 CHANTELL COURT	ELLICOTT (	CITY	HOWARD
	Funeral Director		214-01-7102	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3 – 25 – 19	9. Birthplace (State or Foreign Country) MARYLAND
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Maryl F sho	ţō	MD HOWARD		ITY	1 □Yes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	23a c	ral	8911 CHANTELL COURT	21043		U.S.A.
920	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or Items 23a or 28a-f show event, the Predict Eventhan nutter or offined at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give  Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto In The Specify:</li><li>1 ☐ Yes 2 X No Specify:</li></ul>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	nin 72 ho e. In "natur Medical	Completed	(Specify only highest grade completed) (	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	ing 16b	b. Kind of Business/Industry
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Maryland	be d d e	Be	17. Father's Name (First, Middle, Last)  JOHN CHARLES KNELL		(First, Middle, Maid	,
<u> </u>	d 2 should th and Men 7 is marke traumatic	욘		CAROLIN		(GREIFZU)
	d 2 s th ar 7 is trau		1	Mailing Address (Street and Number or Rura		OTT CITY, MD
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Ē	. Page: tment o tant: If i jury or			S OF FAITH C 12-2	23-08 В	ALTIMORE, MD
Baltimore,	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CVA	ACH/ROSE	DALE FUNERAL HOME SEDALE, MD 21237
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	-	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a gover dis en		Onset and Death
	/Medical Examiner		Due to 🕶 s a con expense of	1. F. 1.	zeine	(0)
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		zen	(040)
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Š,	rificate be executed g physician and as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of			
09/89	cate b	edical	d			
	± 5, 42 I		IF FEMALE: 23c If year outcome of programmer			
C. Box	w requires that the death cer been signed by the attendin should be detached for use:	hysician/N	23b. Was decedent pregnant in the past 12 mords?  1 ☐ Ves 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
7.	requires that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
g	quire; en sig uld be				1 ☐ Yes	2 No 3 Probably 4 Unknown
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
	Phys r this ral dii	2	1 ☐ Yes 2 ☐ No	,	me 5 Residence 28d. Describe how in	6 Other (Specify)
VISION	Attending r death. ector: Afte by the fune	tion	1 Natural 5 ☐ Pending (Month, Day, Year) Inju 2 ☐ Accident investigation		tod. Describe now ii	ijury occurreu
DIVIS	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 2	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
:	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, and manner stated.	leath occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
:	To th To th comp	Me	29b. Signature and title of ceryffier	29c. License number	29d.	Date signed (Month, Day, Year)
			1 / Anna placice	m 102976	9 1	2/22/08
	11		30. Name and address of person who completed cause of death (frem 23a) (Ty	pe, Print)	6 0	24728
	Stat	0	31. Date filed (Month, Day, Year) 32 PRegistrar's Signature	5/600 tollen	y tel 1	Sulx Wid
	Registra		DEC 2 2 2008	The state of		

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** DSAM Herman Cornish Jr December 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore HOSVITE SPACIAITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 6, 1934 6. Sex 7. Age (In yrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Maryland 74 216-30-6817 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ty⊟Yes 2⊟No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 2700 N. Charles Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 domestic hotels 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Keys Herman Cornish Sr ပ permit. Pages 1 and 2 should Department of Health and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3045 Walbrook Avenue Baltimore, MD 21216 Cora Whiting/cousin Important: If item any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state 21. Si nature of Funeral Service Lice State Anatomy Board 655 W. Baltimore Street Wade 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** microbia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Inknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 25. Was ase referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 1 npatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Tyes 2 □No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) Charles St. Baltimore, 147 21230 601 S. 31. Date filed (Month) Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1,0000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patricia Marie December 2008 3:54 $P^M$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03/09/1942 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1 □ M 280kF Months Days Yrs. 212-40-3430 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Worton Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes ② No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Michael Charles Jancewski Mary Agnes Heck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Henry Duke (Husband) 327 Worton Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens Of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/24/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Bruzdzinski Funeral Hone, P.A. 21. Signature of Foneral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immy iate Cause (Final weeks disease or condition resulting in death) Due to (or as conseque ce of); eripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: \_\_\_ Other:

The law requires that the death certificate be executed burial-trans and Box 68760, ing physician attending properties for use as signed by the a d be detached for Ö 0 of Vital Records, icate has been s ; page 2 should should certificate After this c funeral dire Division

Examine Physician/Medical þ Completed Be ျ Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

Director

Funeral

\$

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machal Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

or Attending Physician: death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f To the Hospital

1 162 5 140	1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 ∐ DOA   1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending investig.	ation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying (Check only one) 2 Medical E	g <b>Physician:</b> To the best of my knowledge, dea <b>Examiner:</b> On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	by they wo	29c. License number	29d. Date signed (Month, Day, Year)  De canber 27, 200 f

State

Registrar

Medical

AiRiley G BMC 31. Date filed (Month, Day, Year)
DEC 2

N. Charles St. Balto. Md Z120x 6701 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

marke

08-09451 Warren Davis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death				R	leg. No.	201	00 1.	000
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		4a. Facility Name (if not institution Sinai Hospital	n, give street and number)		4	b. City, Towr Baltimor		ation of I				unty of Deat		
Funeral		5. Social Security Number	6. Sex 7. Age (	In yrs. last bir	thday)	If Under 1		Under	_	B. Date of B	rth(MM/DD/Y	(YYY) g. Bi Forei	rthplace (State	or
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Di Di Di Di Di Di Di Di Di Di Di Di Di D	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street or Town, State) 5403 Fairlawn Ave									wn Avenue,	Baltimore	e, Md.	
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Division of Vital Records, P.O. Box 68760, To the Ilospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Direction After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		aminer:On the basis of exam and manner stated.	ination and/o	r investiga				urred at	rne time, dai				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR CITY BALTIMORE f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Fore Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 **X**M 2 □ F 81 218-22-7237 Director April 5, 1927 <u>Maryland</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It w Michical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 W. Ostend Street 21230 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White Completed by 3 → Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Work Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Dyson Catherine L. Schnider ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Dyson 4505 Owens Valley Drive, West River Maryland 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 12/23/2008 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1 Cemetery 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. Cedar Hill 21. Signature of Funeral Service Licensee Esv GNAZO 130 E. Fort Ave. Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown Month Year 5 ☐ Other (specify) detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 filled in by the funeral director, page 2 should be 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 Inpatient ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and ATTENDINE PHYSICIAN

State Registrar 30. Name and add

NILANTITA (G)
31. Date filed (Month, Day, Year)

SOUTH HANDLER SPREET: BALLIMORE MARYLAND 21225

ss of person who completed cause of death (Item 23a) (Type, Print)

2008

9

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:30P CAROLYN COWAN **DEVILBISS** December 18,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1 Southerly Court #404 Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 13,1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 □ M Hours Mary land 213-36-9530 72 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2√ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21286 USA 1 Southerly Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 Yes XX No Specify þ XX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wallace Cowan Nancy Elizabeth Bowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dtr 6 Shawnery Court Baldwin Maryland 21013 Katherine D Weglein 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State Druid Ridge Cemetery Pikesville, Maryland Dec 22, 2008 4 Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 ignature of Funeral Service Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any local, the mind cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a, Was an this certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) After thi 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. neral Director / filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

30

State Registrar

land 31. Date filed (Month, Day, Year)

29b. Signature ap6 title p

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me, g886,12/19/18dhb

Certificate of Death

Reg. No. C. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James W. **Dumas** Month **Physician** 6,2008 Comes ecember /Medical not institution, give street and number, Town, or Location of Death 4b. City, 4c. County of Deat Examiner Satimore Baltimor 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Sex 1X M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Manth, Day) **Funeral** Min. Months Days Hours 721.05.728 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Baltimore 1 ☐ Yes 2 No **Funeral Director** 1 days town 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3335 Soud 12. Was Decedent Ever in U.S. Armed Forces? 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married ,0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (Q-12) College (1-4or 5+) Economist iculture 12th grade Syears tariculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manie Parker Randall မ mant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balark Health a em 27 is Court Windsor Mill, MD 21207 Summarcet Department of Health Important: If Item 27 any injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD oudon 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee C. Greene Funeral SVO Randallstown MD21132 23a. Part 1. Enter the dis shock, or heart fail. sease, or complications that caused the death. Do not enter the mode of dying, such Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) CERTIFICATA Division of Vital Records, P'O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Yea 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐ Yes 25. Was case referred to medical examiner?

1 Yes 2 Theo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mapner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury To the Hospital or Attendi. within 24 hours after death. To the Funeral Director: A € ☐ Accident Unknown Unknown M 1 □Yes 2 X No Unknown 6X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Unknown Unknown 29a. Certifier 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) artz 32. Registrar's Signature 31. Date filed (Month, Day, Year) State one elect DEC 1 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Many and Department of Health and Wental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 7:30 PM Ethel D. DeMinds 2008 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Care Center Essex
If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Hours Months 1 □ M 2 🛣 F 76 Director 213-30-4188 05/22/1932 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examinant must be notified at Director 1. Yes 2 □ No 28a-f Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a Funeral 3 Pantley Ct. Apt 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛪 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à 3 Widowed 4 Divorced 'natural", Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Italy May Own Home Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Smith Ethel McKeel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene L. DeMinds/Son Pantley Ct. Apt. K Middle River, MD 21220 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial → Oremation 3 □ Removal from State Dec 19 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland 2008 Garrison Forest Veteran 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives Marvland
Approximate
Interval Between
Onset and Death 8717 Green Pastures Drive Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Donknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death

Director:
d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed

2008

31. Date filed (Month, Day,

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>008</u> Month **Physician** рм Carlos F. Edwards December 12. 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Owings Mills 8 Brandwine Crt 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min 1⊠ M 2□ F Months Days Hours Director 218-58-31.35 December 26, 1952 Republic of Panama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other than "natural", or items 23a or 28a-f show vent, the Wedical Examiner must be notified at **Funeral Director** MD Baltimore Owings Mills 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 8 Brandywine Crt. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1972— If ¥ês, Give Year or Dates: 1987 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify: Panamanian 3 ☐ Widowed 4 ☑ Divorced 1987 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Center Director 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F Edwin Edwards Viola Dean Pages 1 and 2 should nent of Health and Mer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 8320 Tapu Crt Nottingham, MD 21236 Carlos M. Edwards/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/08 Garrison Forest Veteran Owings Mills, MD 22. Name and Address of Facility Wile Funeral Home PA of BaltimoreCounty 9200 Liberty Rd Randallstown, MD 21133 23a. Part 1. Enter the disease or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 33 Montus /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of death? page performe 2 No 1 ☐ Yes Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending investigation 1 ☐ Yes 2 No filled in by the fi 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical completely and manner stated 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

2.

3001

MANGUER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5c do

40

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ELLIS DECEMBER 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST TOWSON HOSPICE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗶 F 212-52-3395 Director OCTOBER 3, 1951 MARYL Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expraisor in ust be notified at once. 1 ☐ Yes 2 XNo PIKSSVILLE Director MARYLAND BALTIMORE 10e, Street and Number 10g. Citizen of What Country? 4315 BEDFORD U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo \$ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL RESPIRATORY THERAPIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( CHRISTOPHER GERTRUDE ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERTRUDE PETERSON (MOTHER) 2926 WOODLAND AVE., BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CREMATORY 12-29-2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL HOME
2140 N. FUTON AVE. BALTIMERE, MD 21217 21. Signature of Funeral Service Licensee illiamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 coist Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 □Yes 2 4 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSCICE 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours arter co...
To the Funeral Director: Aft investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
DEC 2 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ar) 32. I gistrar's Signatura

The state of

6701 N. Charles ST TONSON INS

Amend Item 23a per me, 8886,12722/08dnb Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg, No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 10, 2008 Physician 9:05 PM Lotta J. Fotia December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-13-1915 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 ☐ F Months Days Hours Coun 179-09-8637 93 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10b. County Dundalk 1 ZYes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 31 Liberty Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antoinette Unknown Adam Lubashewski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Boxelder Drive, Edgewood, MD 21040 19a. Informant's Name/Relationship (Type. Print) Joseph F. Fotia, Jr.-Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 12-12-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner week toute CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) □Yes 2 ☑No 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying, cause given in Part I. Division of Vital Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 1 ☐Yes 2 ☐No 2 1No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ✓ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. 1 Natural 5 Pending after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours a Hospital within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 1) ecenber 17, 200 8 N Charle St. Balto. Mil 20204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMC 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23,27,28a-f Department of Health and Mental Hygiene per me, g886,12/19/08dhb Certificate of Death Reg. No. 1 - State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7 - 2008 5:15M **Physician** 7CH /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TOWSON MOZIZOX MANOR 10W506 ITGE JORDED. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖫 F 2110-24-1081 Yrs. Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show BAUTIMOR & MD HALL 1 ☐ Yes 2 ☑ No notified ERROY Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or items 23a or Examiner must be USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Black & Decker Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Kahl George Gerst ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5134 New Gerst lane Perry Hall, Maryland 21128 Rosemary Singleton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of HIMPortant: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State St Joseph Ch. Cem. December 10 2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ecenses Lassahn Funeral Home Inc <del>7401 Belair Road Baltimore</del>, -Maryland 21236 Approximate Interval Both 23a. Part1. Enter the disease, or com shock, or heart failure. List only r complications that caused the death. Do not enter the tonly one cause on each line. Interval Between Onset and Death (course 5 Immediate Cause (Final atura **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed My VIUG bunial-transit that initiated events resulting in death) Last attending physician and Due to (or 1/2 a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1☐ Yes 21 No the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division or Vital Record Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy COUNTY) 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 21 No Certification: To this 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? A ter Unknown M Tid Natural 2 Accident 5 Pending investigation 05/117/2008 Subject fell. 1 ☐ Yes 2 X No death. within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 5134 New Gerst Lane Perry Hall,MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide **Home** Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K08021 0 CRNX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIETTE 209 LHAR

Registrar

DHMH 17 Rev 1/2001

State

JA ME

31. Date filed (Month, Day,

Year)

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

Physician	ı
/Medical	ı
Examiner	١

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is the direct from the motified at

Baltimore, Maryland 21215-0036

**Physician** / /Medical Examiner

a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Purperal Director: After this certificate has been signed by the attending physician and letely filled in by the inneat director, page 2 should be detached for use as the buriat-transit etely filled in by the inneat director, page 2 should be detached for use as the buriat-transit Box 68760. P.0. Division of Vital Records,

within 2.

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 21, 2008 Charles William Flemming 7:20 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death V.A. Baltimore Rehab. Extended Care Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 215-38-7748 95 05/29/1913 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Baltimore Director 1 ☐Yes 2 X No Essex 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1000 Arncliffe Road 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1936- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: ģ Specify: 1962 White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Serviceman U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) William Flemming Margaret Rheams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tra once. Doris Flemming (Wife) 1000 Arncliffe Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arlington Nat'l Cem. 02/20/2009 Arlington, Virginia 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fundal Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease <u>Years</u> disease or condition resulting in death) Due to (or as a consequence of) Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXIIInknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**∑M**ud 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Medical 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D41365 December 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. George E. Wicks, M.D., 3900 Loch Raven Boulevard, Baltimore, Maryland 21218 32. Registrar's Signature 31. Date filed (Month, Day, Year) market DEC 2 2008 2

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-22-08 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 0250 A M FIGGS MORRIS 20 2008 PECEMBER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Months Days 1 XM 2 □ F 73 Yrs. 215-32-7925 12-21-1934 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 502 Linwood Ave 21205 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced R1ack 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Larborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Jefferson Louis Figgs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21217 1510 Mosher Street Apt-51 <u>-Sister</u> Lillian Figgs 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Reisterstown, MD Y Burial 2 ☐ Cremation 3 ☐ Removal from State
Donation 5 ☐ Other (Specify) 27 December 08 St. Luke Cemetery 22. Name an Address of Facility 21. Signature of Funeral Service Licenses Funeral 639 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILURE 3 Lays. Due to (or as a consequence of) 31 days METASTATIC BRAIN TUMOR Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown thourtersing. Cororany 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2**)** ∠ No 26. Place of Death (Check only one) Hospital: Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

/Medical **Examiner** and A or Attending Physician: The law requires that the death certificate be executed burial-1 physician is the buria Division of Vital Records, P.O. Box 68760, as attending p d by the al certificate I Director: After this ed in by the funeral d this death. after within 24 hours a
To the Funeral C
completely filled the Hospital

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

Be

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**Funeral** 

Director

in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with

al Hygiene.

th and Mental Hygie 27 Is marked other traumatic event, the

of Health permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.

**Physician** 

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be examiner?
1 Yes 2 XiNo ၉ 27. Manner of Death 1 Natural 2 ☐ Accident Certification: 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number -29b. Signature and title of certifier ZES-000. DECEMBER 20, 2008

State Registrar

The Johns Hopkins Hospital MARI GROVES 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Year **Physician** 12 23 AM 2008 REGINALD ERNEST GRINAGE 12 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUO Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT 4 1956 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral XX**M 2□ F Days Hours Min. MARYLAND Director 215-66-3537 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □ Yes 2/□XNo Director BALTIMORE BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a U.S.A. 1655 HOPEWELL AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MIDDLE RIVER AIRCRAFT FABRICATOR 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARGARET SMITH Injury or other traumatic REGINALD MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sha Department of Health and Important: If item 27 is m any Injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 1655 Hopewell AVe., Baltimore, Maryland 21221 Nellie E. Grinage/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Xurial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY GRDNS 12/20/08 4 ☐ Donation 5 ☐ Other (Specify) TIMONIUM, MARYLAND 21. Signature of unerby Service (cerisee 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, PA. Dealun 321 S PHILADELPHIA BLVD, ABERDEEN, MD. 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ulmorary em 60/15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi 0605 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sh autopsy performe 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: /
filled in by the fi 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 30. Name and address of person who completed ca DR michael 760 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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			For		State of Ma	ryland /	-				ental Hy	giene	and the second	
1 - State Registrar					Certificate of Death					Reg. No. 2008 403				
	Physicia	1. Decedent's Name (First, Middle, Last)										ath Day	/ Year	3. Time of Death
	/Medic	-	70H		GURNE.	Y						R 11	×	<u> </u>
	Examin	er			street and number)			4b. City, Town,				4c.	County of Dea	ith
٠	391.		HARBOR HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth									th	9. Bir	thplace (State or Foreign
	Funeral Director	Months Day								Min.	(Month, Da Jan 7, 19	iy, Year) 925	C	ountry) MD
-	Separa challe into		Usual Residence o											
	arylan show d at	_	10a. State	10b. County		10c. City, Tov								10d. Inside City Limits 1 ☐ Yes XX No
	8a-f s	Director	MD	Anne Arunc	lel	Glen B	urnie					40		
	with the be no	P.	10e. Street and Nu 6425 Linco			10f. Zip Code 21061						10g. Cit	izen of What C	
	eath	eral	11. Marital Status		12. Was Decedent E	ver in U.S.	13. V			rigin? (Spe	cifv Yes or No	)- T	14. Race - Am	USA erican Indian,
	fter d r Item	Funeral		ried 2 Married	Armed Forces? 1XX)Yes 2 ☐ N	lo.		Vas Decedent of f Yes, specify Cul			Rican, etc.)		Black, Whi	
3	ral", o	þ	3 Widowed		If Yes, Give Year or Dates:	~ 1961 <b>-</b> 1973	1	I□Yes XX No	Specify	<i>'</i> :			Specify:	White
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4	vithin ne. han "	ם	Elementary/Seco		College (1-4or 5-			OO NOT use retire	-					
V	iled w Hygie ther t		17 Father's Name	(First, Middle, Last)		5	<u>enior</u>	Chief Pet	1		(First, Middle		Navy Surname)	
<u> </u>	d be fantal h	) Be	John T. Gu	irney, Sr.							George	maiden	ourname,	
<u> </u>	shoul nd Me mark imati	ျှ	19a. Informant's N	ame/Relationship (	Type. Print)	19	b. Mailin	g Address (Stree	1 t and Numb	ber or Rura	l Route Numb	er, City o	or Town, State,	Zip Code)
To a State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10c. City, Town or									, MD 210	)61				
ָ נ	es 1 a of Her litem		20a. Method of Dis		Removal from State	20b. Place cemet	of Dispo	sition (Name of natory or other pla Veterans	ace)		ate		ocation - City or	
ĺ	Pag ment ant: It			5 ☐ Other (Specif		Crowns	V17)1 e	Veterans	Cem (L	ec 22,	2008	Crown	nsville,	MD 
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fee 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Licer	isee	M01148		Name and Addr Fink Fune 426 Crain				, MD	21061	
			23a. Part . Enter	the isea e, r con	plications that caused one cause on each lin	the death. Do								Approximate Interval Between
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	/Medical		disease or andition resulting in the th)		a. CONCESTINE HEART FAILURE  Due to (or as a consequence of):									
Examiner  Sequentially list conditions.  D. TSCHEMIC CARDIGMYOPATHY														
	ed sit	nine	dany, leading to it cause. Enter Unde	nmediate erlying	Due to (or as a	,								
pernose a grant of miniculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								<u> </u>						
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5	endin r use	Physician/M	IF FEMALE: 23b. Was deceder		23c. If yes, outcome   1 □ Live birth		th 3F	Ectopic pregnan	rv			- di	23d. Date of de	*
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2	or Atterde	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubulding, etc	ry - At home, to: (Specify)	farm, str	eet, factory, office	)	2	8f. Location ( City or To	Street ar wn, State	nd Number or F e)	lural Route Number,
ב	oltal o		00- 0-46	15/0-416-1 101	To the best of	of many law and a state		a accurred at the	**!-+				\ d	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)		ysician: To the best on niner: On the basis of and manner sta	examination a		vestigation, in my	opinion, de					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 0835 AM GOR OUN HATTIE DECEMBER 12,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIONORE HOSPITAL PANDALLSTONA NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F Yrs. Director Maryland Nov 5, 1923 Usual Residence of Decedent 85 filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Baltimore Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21244 3302 Kyle Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hattie William 2 Alexander Christv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3302 Kyle Court Windsor Mill, Maryland 21244 Mark Gordon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Pege Department i Importent: If eny injury or once. Aberdeen, Maryland 12/19/08 Union United Methodist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Furieral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 of enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. (1947) ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** days In trap ar en chajind /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the ettending physicien and the for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 MNo 9 Unknown 9 Unknown δ cete hes been signed page 2 should be dev Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 2 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Satural М 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direc 4 | Homicide 29a. Certifier t. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Durana DU059736 2005 RetMI mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSATAL 5401

State Registrar DEBORAH

31. Date filed (Month, Day, Year)

2008

2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NORTHWEST

PITZPAFRICA

32. Registrar's Signature

#### 08-09408 Ra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iph Gaskins		State of Maryland / Department of		Reg. No.	2000 1.02
Physic	_	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
edical Exam		Ralph Gaskins		Month Day Ye December 14, 2008	20301118
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	1 4c. County	of Death
		3931 Edmundson Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs	s. 8. Date of Birth (MM/DD/YYY	Y) 9. Birthplace (State or
Funeral Director			Months Days Hours Min	1.	Foreign Country Maryland
Directo.		214-56-5930 1XM 2F 56 Yr Usual Residence of Decedent	5.	Apr 13, 1952	Maryland
any		10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
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ne Maryland or 28a-f show any ffed at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V	/hat Country?
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r death with the Maryland or items 23a or 28a-f sho must be notified at once,	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto		e - American Indian, Black, ite, etc.
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	ğ	15 Decedent's Education (Specify only highest grade completed) 16a, Decede	ent's Usual Occupation (Give kind of	work donank 16b. Kind of E	Business/Industry unk
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036 rithin 72 ene. er than	Completed	unk unk		(E. ) Deside Maide Company	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than event, the Medica	ပ္ပ	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surnam	le)
2121 uld be fil Mental F marked	o Be	Ralph Gaskins Sr  19a. Informant's Name/Relationship (Type, Print )  19b. Maili	ing Address (Street and Number or	na Gibson Rural Route Number, City or To	own, State, Zip Code)
, MD 2 and 2 shou ealth and N tem 27 is n	- 1		B E. Lafayette St	reet <u>Baltimore</u>	, MD 21202
e, N l and l Health item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of cemetery,	Date 20c. Location	n - City or Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Burial 2 X Cremation 3 Removal from State  4 Donation 5 X Other Specify: in Charles Metro Cre	_ ' '	/22/08 Balto	. MD
altir mit. I partmo		21. Sign tun of Funeral Price Licenseen 22 Kong d S. Wad, Mrector 22	Name and Address of Facility Jan	gs A. Morton &	Sons F.H.
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Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.		or respiratory arrest, shock, or i	Between Onset and Death
-xamine	•	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	isease		
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ex	Physician/Medical	UNPENDED X AMENDED Item#20a-c&22p	perFH,G886,12/31/	08,WS	
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OX 6876 eath certificat attending ph	cial	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregi	, identity	•
Box 687 e death certifice the attending p	isy	1 Yes 2 No 9 Unknown g Unknown			
ires that the days the signed by the	by P		ie underlying cause given in Part I.		ntribute to the cause of death?  3 Probably 4 Vunknown
D, D				-	o. Were autopsy findings available
cords, law requir has been s	Completed			autopsy performed?	prior to completion of cause of death?
Reco	uo.			1 Yes 2 V No	1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  The Third of After this certificate has been since to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	o Be Con	25. Was case referred to medical	26.Place of Death (Chec		6 ✔ Other: Scene
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Sio	catic	2 Accident Investigation 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.		mber or Rural Route Number, City
DIVI	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)	
Hospi 24 hou Funer			courred at the time, date and place, a	and due to the cause(s) and man	ner as stated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical Certification	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigate and manner stated.			
F » F	§   §	29b. Signature and title of certifier	29c. License number		igned (Month, Day, Year)
		aus C	O.C.M.E.	Decemb	er 16, 2008 
		30. Name and address of person who completed cause of death (Item 23a)	n Street, Baltimore, MD 212	201	
U		22 Pagistraria Signatura	Adv a		
Reg	State istra	0000			
		ULU O O	3221		

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 16:45p M December 15 2008 SARAH Ε. HOGAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 1701 EUTAW ST. **APT 623** BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex Months Days 1 □ M 2 🛛 F Yrs. 58 SOUTH CAROLINA JULY 4 1950 212-56-9756 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County MXYes 2 □ No MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1701 EUTAW STREET **APT 623** 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**XX**No Specify: 3℃Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CASHIER LIOUOR STORE 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES DAVIS MARY SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3319 Winterbourne Rd., Baltimore, Md. 21216 Floyd DAvis/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 12-19-08 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last HOLESTEROL IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autonsy perform 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

any Injury

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Health and Ments em 27 is marked

Pages 1 and 2:

death with the Maryland

Maryland 2121

Baltimore,

Examiner Physician/Medical the þ Completed Be ( Certification: To

ires that the death certificate be executed

Box 68760,

P.0.

Records,

tal

Hospital

25. Was case referred to medical examiner?

2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and litle of sertifier

and manner stated.

29c. License number
D 43472

29d. Date signed (Month, Day, Year) 12/16/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER CHIANG, 24L5 EUTAW

BALTIMORE MO 2121;

Registrar

completely

Medical

31. Date filed (Month, Day, Year)

2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Harrison 0930 M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Center Handalistown Baltimore Northwest Hospitai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral X** M 2 □ F Months Days Hours Min. Director 219-30-3446 Usual Residence of Decedent 70 03 06 MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2 🛣 No Funeral Director Reisterstown Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 523 Gwynnwest Road 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator llth grade Dept of Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Miller မ Wilbur Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 1344 Weldon Ave, Andre Harrison-Son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/08 Baltimore, Md Baltimore 21. Signature of Juneral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ongestive heart disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** -strepe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify). P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Non compliance Be Completed COPP 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CAD 2 **N**0 1 Yes s after deau... ral Director: After this ce.... ⊣in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD57886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tree Rd., Ste. 248 Baltimore MD 21208 MD1838 Pina-Hsin chen Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

31. Date fled (Month, Day, Year)

DEC 2 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10:PM **Physician** Hod mone 12 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City BON Secour If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace Country) (State or Foreign **Funeral** Months Hours 1 2 M 2 □ F Days 219-10-8828 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits State / 10c. City Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinatment to notified at 1 ☑ Yes 2 ☐ No Director mure 10f. Zip Code 10e. Street and Numb 10g. Citizen of What Country Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ 3 ✓ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Mail handler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ partment of Health a portant: If item 27 is rinjury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 Burnal 2 ☐ Cremation oval from State JATTI SYN 4☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licensee uce 23a. Part 1. Enter the disease, or complications 1 at caused the strock, or heart failure. List only one cause of each line. mode of dying, such as cardiac or respiratory arrest. set and Death **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last sician and burial-transit law requires that the death certificate be executed P.O. Box 68760, attending physician for use as the buria YS. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ha 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO C. C. IIENMANU 2000 W. Baltimore St. Baltimore MD 21223

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Shirley A. Hartge DECEMBER. 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Director 213-30-8261 76 Sept 25, 1932 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Whitfield Road 21228 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 🔯 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accounting financia1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Cleo Girton Stella Irene Brown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hartge/son 309 Whitfield Road Baltimore, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sign ture 1 Funeral Service Vicen. State Anatomy Board 655 W. Baltimore Street Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consciuous of): Baltimore, MD 21201 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Due to (or as a confequence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: A pletely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide YSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

o. Division of Vital within 2 To the

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State Registrar (Check only one)

Som Nath

31. Date filed (Month, Day, )
DEC 2 2

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

December. 16,2008

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

900 Caton Aye.

32. Registrar's Signature

8-09443 NK UNK		Please Type or Print in Black Indelible	Ink. Ensure All Copie of Health and Mental Hy	es Are Legible. ygiene	
rilThon	F	1-For State Certificate Registrar	of Death	Reg. No.	3. Time of Death
Physicia Medical Examir	ner	1. Decedent's Name (First, Middle, Last)  Ori Thomas Jackson,  A Script Name (First, Middle, Last)	4b. City, Town, or Location of Death	2. Date of Death Month Day Pear December 15, 2008	2020 hrs
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	Baltimore	102 000111, 0	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min	-	Foreign
Director		WIT 1013 - Od	Yrs.	11.28.1987	Country) MI
any	_ <u> </u>	Usual Residence of Decedent  10a. State			10d. Inside City Limits
iand F show	ō		nore	10g. Citizen of Wha	1 Yes 2 No
ie Maryland or 28a-f show fied at .nce.	Director	10e. Street and Number	10f. Zip Code	log. Citizen of Wha	A
death with the Maryland or items 23a or 28a-f sho must be notified atnee.		3414 Mayfield Me  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? ( St		American Indian, Black,
r death or iten must t	Funeral	1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Specify:	Brock
urs afte	2	15. Decedent's Education (Specify only highest grade completed)   16a. Dece	Yes 2  specify:  dent's Usual Occupation (Give kind of	work done 16b. Kind of Bus	siness/Industry
6 72 hou un "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use reti		
within giene.	Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)	SINWAX
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner	Be C	Oril Thomas Jackson, Sr.	Touc	a stanfield	
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene 77 is marked other than "natural", of maire event, the Medical Examiner.	2	19a. Informant's Name/Relationship (Type, Print )		Rural Route Number, City or Town Baltimore, Mi	n, State, Zip Code)
Md 2 alth			position (Name of cemetery,		City or Town, State
Baltimore, permit, Pages I at Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory of 4 Donation 5 Other Specify:	r other place)	associal Baltin	rore, MD
Baltimo permit. Pag Department Important: injury or of	ı	21. Signature of Funeral Service Licensee	2. Name and Address of Julity Co.	ughn C. Greene Fu	neral services
	- 1	23a. Part I. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest, shock, or hea	art Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
*	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		V W	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated counts routing in death), last Due to (or as a consequence of):			
ecuted and and transit		events resulting in death) Last Due to (of as a consequence or).			
1760, ficate be exe g physician a	edica	UNPENDED AMENDED		Look Date of	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy 1   Live birth 2	Fetal death 3 Ectopic pregn	23d. Date of Month	Day Year
Sox 687 leath certific e attending for use as the	sicis	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
O. B. at the de 1 by the tached f	Phy	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		bute to the cause of death?
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Completed by				Probably 4 V Unknown  Vere autopsy findings available
ords aw requas beer 2 shoul	plet			autopsy p	prior to completion of cause of death?
Rec : The lificate l	S	25. Was case referred to medical	26.Place of Death (Check		Yes 2 No
/ital ysician his cert	o Be	examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 V ER/Outpa	Inther:	ing Home 5 Residence 6	Other:
n of ing Phy	in: To	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1936 br		28d. Describe how injury occurr Subject shot	ed
Sion Attend death.	catic	1 Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm,	1 103 2 4 110	28f. Location (Street and Numb	er or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Street	outout, reacting, and	or Town, State) 2600 Block of East Chase S	
e Hosp 24 hou e Fune etely fi	SalC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check only)	occurred at the time, date and place, an	nd due to the cause(s) and manner	as stated.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investand manner stated.  29b. Signature and title of certifier	29c. License number		ed (Month, Day,Year)
		Al a Mike	O.C.M.E.	OCME December	
		30. Name and address of person who complete to use of lefth (Item 23a)		LID 04004	
5	M 151	Theodore M. King, Jr., MD. Assistant Medical Examine	r 111 Penn Street, Baltimo	re, MD 21201	
S¹ Regis	tate trar	200 200 200 200 200 200 200 200 200 200	9A(32)		

08-09443

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

2. Date of Death Month

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-0			611	

Physician
/Medical
<b>Examiner</b>

**Funeral** Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Box 68760, P.0. Division of Vital Records,

Director 10f. Zip Code 10e. Street and Number Funeral 11 Liberty Parkway 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Teamster permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) Be Joseph Kralic Jr. Rita Gaul 19a. Informant's Name/Relationship (Type. Print) Darlene Canneti sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 22, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Chronic Pain Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Hepatitis Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by cutanea Lumbar Spondylosis 25. Was case referred to medical examiner?
1 Yes 2 □ No Be Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Stephanie Linder 902 Averill Rd Joppa, MD 21085 Stephanie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

20, 2008 Kralic Joseph December 22:44  $\mathbf{P}^{\mathsf{M}}$ Kenneth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dundalk Baltimore 11 Liberty Parkway | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | September | 11,1953 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday 219-60-5359 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Baltimore Dundalk 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Specify: White 16b. Kind of Business/Industry Union 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 8th Street, Sparrows Point, MD. 21219 20c. Location - City or Town, State Baltimore City, MD. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic cardiovascular disease 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) D0043909 December 22, 2008

DHMH 17 Rev 1/2001

08-09	925	0	
John	Ρ.	Koch	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	te of Maryland / De	Certificate of L		na Mentari		g. No. 2	008 4090
Physicia	an/	1. Decedent's Name (First, Middle,	Last)				Date of Death     Month	n Dav Yea	3. Time of Death 1442 hrs
Medical Exami	ner	John P. Koch  4a. Facility Name (if not institution,	give street and number)	4h	City Town (	or Location of Dea	December	9, 2008 4c. County of	Charles and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr
)		703 Hammond Street			Salisbury			Wicomic	
Funeral Director		212-50-7071		yrs. last birthday) 50 yrs.	If Under 1 Ye Months Da			,	9. Birthplace (State or Foreign Country) Maryland
and and an area.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location .							10d. Inside City Limits
*	Ē	MD Wicomi	Lco	Salisbu	ıry				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 703 Hammond St	reet		10f. Zip Code	21801	10	g. Citizen of Wr USA	•
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Mar	1 Yes 2 X	If Yes	s, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	White	
hours afte 'natural" Examíne	d b	3 Widowed 4 Divor	ced If Yes, Give Year or Dates: 'y only highest grade complete	ed) 16a. Decedent's	es 2 X N	ation (Give kind o	f work done 11nk		white siness/Industry
D 21215-0036 should be filed within 72 hou and Mental Hygiene. 7 is marked other than "name event, the Medical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	t of working li	fe. DO NOT use re	etired)	1 100	mprovements
15-0 filed v I Hygin of othe		17. Father's Name (First, Middle, L					ne (First, Middle, M		)
2121 uldibe fi Mental marked	To Be	Paul Michael  19a. Informant's Name/Relationshi		19b. Mailing A	Address (Str		homasina Rural Route Num		n, State, Zip Code)
MD d 2 sho tth and n 27 is		O.C.M.E.		111 F	enn St	reet Bal	timore,	MD 212	01
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation  4 X Donation 5 Other Spe	3 Removal from State	20b. Place of Disposition crematory or othe		emetery,	Date	20c. Location -	City or Town, State
Balti permit Departm Importa injury o		Som ture of Funer Larvice L	wade. Direc	Ba1	timore	MD 21	201		nore Street
Physician /Medical •xaminer		23a Part I. Enter the disease, or c failure. List only one cause of Imme ate Cause (Final disease	omplications that caused the d n each line. Acute a1 a. Atherosclerotic Gard	eath. Do not enter the .cohol into	mode of dyin Xicati	<ul> <li>such as cardiac</li> </ul>	or respiratory arre	est, shock, or hea	Approximate Interval Between Onset and Death
		or condition resulting in death)	Due to (or as a consequent b.	nce of):					
	ner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause	Due to (or as a consequen	ice of):		\$1 × 1			
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequen	nce of):					
xecuted a and ransit	Ê		d. 23a.2	<del>7,28a-f, p</del>	erMe.	<del>C887 1/2</del>	<del>፡ 3 /በዓ - ተ</del> ጉ		
760, cate be exe physician a	Medical	UNPENDED	X AMENDED	7,20a 1, p	, , , , , , , , , , , , , , , , , , , ,		.5/07 11		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	23c. If yes, outcome of  Live birth  Pregnant at time  Unknown	2 Feta	l death 3 er (Specify)	Ectopic preg	nancy	23d. Date of Month	delivery Day Year
P.O. E		Part II. Other significant condition		not resulting in the und	derlying cause	e given in Part I.			ibute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.C ral or Attending Physician: The law requires that its after death.  al Director: After this certificate has been signed to led in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed.	Completed by						24a. Was a autop:	med?	Were autopsy findings available prior to completion of cause of death?  Yes 2 No
tal Rection: The certificate ector, page	ادہ	25. Was case referred to medical			26.Pla	ce of Death (Chec		2 140	V Tes 2 No
Vital hysician: this certiful director,	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient			sing Home 5	Residence 6	✓ Other: Scene
1 of Vit ding Physic After this funeral dire		27. Manner of Death	28a. Date of Injury (Month, Dey,Year)	28b. Time of Inju		jury at Work?	28d. Describe h	ow injury occurr	red
Siol Attener death ector: by the	catio	2 Accident Investi	gation Place of Injuni	8 unk At home, farm, street,				treet and Number	er of Rural Route Number, City
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 X Could determ	not be	home	ractory, omco	building, etc.	or Town, Si Salis	bury, M	er or Rural Route Number, City AMMOND S C D
the Hos hin 24 h the Fun	Medical (		sician: To the best of my knowiner:On the basis of examinati						
To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			nse number			ed (Month, Day, Year)
		Of alm	feul)		0.0	C.M.E.		December	10, 2008
		30. Name and address of person w Laron Locke MD. As:	ho completed cause of death of sistant Medical Examin		Street, Balt	timore, MD 21	201		
		31. Date filed (Month, Day, Year)	32. Registrar's Sig		<b>8</b>	···			
Regist	rar	DEC 2.2.2	008 Beaute.	AND THE RESERVE	Kelenge				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b perFH, G886, 12/24/08, Ws
State of Maryland 1 Denartment of Health and Mental Hygiene

			for State Registrar	State of Ma	ryiana / Depa <i>Cei</i>	rtificate of			giene Reg. No.	000	Lagns	
Ī	Physici	an	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	ath Day	Year	3. Time of Death	
	/Medic		Albert L. Kahme					Decemb	cember 16, 2008 3:15 PM N			
	Examin	er	4a. Facility Name (If not institution, gi	· ·		4b. City, Town, or	r Location of Death		4c. County of Death			
age "			Upper Chesapeak  5. Social Security Number 6.		(In yrs. last birthday)	If Under 1 Year	Bel Air	8. Date of Birth	Hari		lace (State or Foreign	
	Funeral Director			1 M 2 F 7. Age	59 Yrs.	Months Days	Hours Min.	(Month, Day 12/01	v, Year)	Coun	try)	
	iryland show	_	10a. State 10b. County		10c. City, Town or Lo	cation	<u> </u>		<u> </u>	10	0d. Inside City Limits	
	Ba-f	Director	MD Harfo	iore	Baldwin						1 □ Yes 2. No	
	if th	E E	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	ath w		2906 Placid Dr.			21013			USA			
36	s filed within 72 hours after death with the Maryland al Hyglene. other than "natural", or items 23a or 28a-f show yent, it a Madical Evanirat must be nythind at	by Funeral	11. Marital Status 1 ☐ Never Married 22 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2⊠.No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, e		
ခု	hour tural	be	3 Widowed 4 Divorced	Year or Dates:	16a Dago	dent's Usual Occup	ention			Whi		
215-0036	n 72 n"na	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	kind of work done of	during most of work d)	ing	16b. Kind of E		lustry	
212	withi iene. thar	E O	Elementary/Secondary (0-12)	College (1-4or 5+	-)	motive Me			Autom	otive		
		BeC	12. Father's Name (First, Middle, Las	;)	Auto	MOCTVE IN	18. Mother's Name	e (First, Middle, .	Maiden Surnai	ne)		
Maryland	Ø 2 ≥ Ø o	To B	Louis Valentine	Kahmer			Alma Lo	uise Her	da			
ä۲	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Rur			, State, Zip	Code)	
	od 2		Brenda Lee Kahme	/Wife			Dr. Baldv		-	,,,	,	
ē,			20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location	- City or To	wn, State	
Ê	Pages nent of int; If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				i	Dec 19	Balter	ille	Maryland	
Baitimore,	permit. Pages Department of Important: If in any injury or once.	( 9	21. Signature of Funeral Service Lice		1 00	ake Crema	O - O - I - O - O - O - O - O - O - O -	2008	Delcav	TTTE,	Maryrand	
ñ	Deg any	17	da de luc	B. Ol	गपप्उ 2		and Funer				7	
			23a. Part 1. Enter the disease, or con	plications that caused t	the death. Do not ent		n Pastures ng, such as cardiac			се, ма	Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	э.						Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):					_	10 moths	
	Examiner			800	,							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):							
	cuted nd ransit	Examiner	Cause (Disease of injury that initiated events	C.								
o o	an ar		resulting in death) Last		consequence of):							
8/60,	rificate be executed g physician and as the burial-transit	edical		_d								
	ng ph	Med	IF FEMALE;	2							·	
.C. BOX	the death cer y the attendin ched for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknowh	23c. If yes, outcome o  1  Live birth 2  4  Pregnant at 1  9  Unknown	Petal death 3 ☐	Ectopic pregnancy Other (specify)	у		1	ate of delive onth	ry Day Year	
Ţ	that ned b		Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?	
ecords,	law requires that the dias been signed by the 2 should be detached	ted by						1 🗆 Ye	es 2□No	3 Proba	ably 4 ☐ Unknown	
Lec	The law ite has b	Completed		<del>.</del>	<u> </u>		<del></del>	24a. Was a autops perfori	sy med?	prior to con death?	osy findings available inpletion of cause of 2 No	
VII	ian: rtifica stor, p	BeC	25. Was case referred to medical				26. Place of Death		/	1 □ Yes	2/11/10	
_	nysic nis ce direc	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien	t 2 ER/Outpatien	t 3 DOA Othe	er: 4 ☐ Nursing Ho	me 5 ☐ Reside	ence 6 □Otl	ner <i>(Specify</i>	·)	
Sion or	nding Physician: The I th. : After this certificate ha s funeral director, page	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day,	Year) 28b. Time of Injury	28c. Injury Work M 1 🗆		28d. Describe ho			,	
NIN IS	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, farm, stre (Specify)	eet, factory, office		28f. Location <i>(Si</i> City or Town	treet and Numl n, State)	ber or Rural	Route Number,	
	ne Hospit n 24 hour ne Funera pletely filk	Medical (	29a. Certifier (Check only one)  Certifying Plant   2 Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Example   Medical Exam	nysician: To the best of miner: On the basis of and manner state	examination and/or in	occurred at the ting restigation, in my o	ne, date and place, pinion, death occur	and due to the o	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)	
	To the comp	Ň	29b. Signature and title of certifier			29c. License	number	2	29d. Date signe	d (Month, E	Day, Year)	
			10	~		Don	66912		12/19	1/200	9	
	12		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, I		11 1	100		/	200	
	Sta	te	31. Date filed (Month, Day, Year)	32. fegistrar	's Signature.	NO. Do	LAC	110 2	10145	Soits	200	
	Registra	ar	DEC 2 0 2	2008	J. 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤎 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician**  $P^{M}$ Lewis Maryanna December 18, 2008 7:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Riverview Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Pear) | August 16, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 F Mary land 213-01-7453 92 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examit or mitted to collical at 1 ☐ Yes 2 No Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 529 S. 45th Street 21224 USA Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 9 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Beauty Salon 7 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Leonard Wiessner Magdalena Brywczynski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 Is any injury or other trau Barbara Fergison Daughter 529 S. 45th Street, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 20, 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** /Medical UCTIVE PULMONARY DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify). 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 **1** No 2 1 MG 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760,55 Ö Division of Vital Records, within 24 hours after deam.
To the Funeral Director: /

Baltimore, Maryland 21215-0036

V

(Check only one)

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Time of Death 18 Day Month 10:30 £M **Physician** DEBORAH LASSITER /Medical 4b, City, Town, or Location of Death
ATTIMONE, MD 3133 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HON SECOURS TAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) N. CAROLINA 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**X**F Days 218-26-6466 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 1 Ses 2 □ No **Funeral Director** MARYLAND BALTIMORE 10e. Street and Number 10g. Citizen of What Country? POPLAR GROVE ST. #10C 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Specify: þ Specify: BLACK 3 ☑ Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 11TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 Is marked o HAMILTONI permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev EUGENE MARY WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAMPTON (BROTHER) 949 POPLAR GROVE ST., BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 13/23/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOSEPH H. BROWN JR. FUNERAL HOME Mams 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS **Physician** /Medical Due to (or as a consequence of): CHOLE CYSTITIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month P.0. 1 ☐ Yes 2 🗷 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by BEHYDAADION; UTI COMONARY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HUPOTH Y ROID 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No OBFSITH 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier morhbeli, m.D 114949 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7777 W. BRUTIMUNE WALET V- MOEHBELI mo BALTIMUNE, 31. Date filed (Month, Day, Year) 32. Pajistrar's Signature 22 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month 12 **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE - WASHINGTON MEDICAL CENTER Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 14,1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 M 2 □ F 218-26-6178 79 **Director** Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Maryland Anne Arundel Brooklyn Park 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 115 Cedar Hill Road 21225 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Mold Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene F. Lybrook Minnie M. Hutchinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5070 Stone Hill Drive, Ellicott City, Maryland 21043 Donald E. Lybrook Jr (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 12-22-08 Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funer Service Licenses McCully-Polyniak Funeral Home P.A. any 237 East Patapsco Avenue, Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death prock, or heart failure. List only one cause on each lihe. Do not enter the mode of dying, such as cardiac or respiratory arrest, Impediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-transit Due to (or as a consequence physician a Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performe 1☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 2 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who comple d cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

RAMERTZ

31. Date filed (Month, Day, Year)

32. Registrar's Signature

301 Hospital Drive, Glen Burnie, Maryland 21061

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 154 50 M Maria A. Lambros December 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 219-28-5133 Director 85 Nov 30, Ohió 1923 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 □Yes 2√□No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4047 Rustico Road 21220 **IISA** permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, Inc Medical Expanical mans by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) telemarketer appliances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Sidiropoulos Sophia Filidou ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nick Lambros/son 4047 Rustico Road Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si naturi Pin ral Si vice Rona I 22. Name and Address of Facility , Wade State Anatomy Board 655 W. Baltimore Street 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate use (Final disease or condition resulting in death)

a. 

Pat Ince Approximate Interval Between Onset and Death **Physician** Weeks /Medical Due to (or as a consequence of Examiner litral Valve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Hypertension
Due to (or as a consequence of): and P.O. Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Chroniz Obstructive Discas IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate has 1 □Yes 2 DNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 0 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mann of Death completely filled in by the funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO AT 243 89 46 December 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, Baltimare, MD BURGOYNE, MO GREG Union Memorial 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** LRUIN MEEKINS 112 PM nec 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPITALCENTER WESTMINSTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG 18 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F MARYLAND 220 72 1348 5 Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglen. Subsection (I fem 23 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extiniter must ten willfied at Director 1 ☐ Yes 2 No mp CARROLL SYKESVILLE 10e. Street and Number 10g. Citizen of What Country? WENDY ROAD 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CatursvillE College (1-4or 5+) Elementary/Secondary (0-12) PACILITIES TECHNICIAN SUPERO Community ColleGE 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IDA TRENE BURNS STERLING MEEKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYKESUILLE MO 21784

20c. Location - City or Town, State CHERYL SISTER 304 WENDY ROOM SMITH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 SQ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LAKE VIEW Mem. PK 12/24/2008 Sykoville, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBRW FH & MON. Co. 6028 SYKESVILLE ROAN ELDEN BURGMO 21784 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Very culor acheardyo 5minutes /Medical Due to (or as a consequence of): Examiner Osstructure Chronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Marbid Obesity Due to (or as a consequence of): U Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔀 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

certificate be executed Box 68760 P.0. Records, of Vital Division

Baltimore, Maryland 21215-0036

and burial-trar attending physician the as nse s for the certificate has page To the Hospital or Attending Physician: After this death. within 24 hours after death

To the Funeral Director: /

show

Medical

State

Zalman Kahn 31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

almon Lohness

29a. Certifier

(Check only one)



**ORIGINAL** 

December 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 304

VS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Wesminsta, MO 21157

412 Malcolm Blad

and manner stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09453 State of Maryland / Department of Health and Mental Hygiene Shavonia Murphy 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 0402 hrs December 16, 2008 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore** Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** oreign Months Davs Hours Min Country Director 2 М Residence of Deceder 10d. Inside City Limits Town or Location Oc. City, iny 10a. State 10b. County 2 No 28a-f show . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Married 2 No Yes If Yes, Give Yea Specify No 4 Divorced 3 Widowed ģ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DQ NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) Baltimore, MD 21215-0036 . Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address 20b. Place of Disposition (Name of c crematory or other place Removal from State mportant: 21. Signal MO155-Approximate Interva or complications that caused the death. Do not enter **Physician** Between Onset and failure. List only one cause on each line. Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED the attending physician ed for use as the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy Year 23b. Was decedent pregnant in the Month Dav Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 V Unknown detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Status post colon surgery with colostomy Completed 24b. Were autopsy findings available 24a Was an certificate has been prior to completion of cause of autopsy death? performed' Yes 2 ✔ No Yes 2 No page 26.Place of Death (Check only one) uneral director, 25. Was case referred to medical Be Other<sub>4</sub> examiner? Residence Other 2 V ER/Outpatient 3 DOA Nursing Home 5 Inpatient this မ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Medical Certification: 1 V Natural Yes 2 No Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD.

(Specify)

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

December 16, 2008

Registrar

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** OUZON John 14,2008 ecember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours March 26, 1949 N orch 700 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 1 Xves 2 □ No Director Ilmore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2121 naus 23a Funeral must Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No ŏ Baltimore, Maryland 21215-0036 Specify: Specify. ģ 4 Divorced 3 UWidowed "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation item 27 is marked other than "natu other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be 1042a and Mental Norma MA ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Benning haus Ro Tia Mouzon daughter 701 eto, mas of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 12/20/08 tonsulle imD 5 Other (Specify) remalone 4 Donation 21. Signature of uneral Sorvice License 270 P. marih Fit. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shock Onset and Death Immediate Cause (Final **Physician** Nu neumonia disease or condition resulting in death) Due to (or as a consequence of) /Medical **Examiner** Vere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) tha Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 25 No 2 Fetal death 1 Live birth 3 - Ectopic pregnancy Month Day completely filled in by the funeral director, page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Unknown 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \sum Nursing Home Hospital: 2)XNo 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 1 Tes Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical and manner stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier recember 14. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Sm mer 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 DEC 2 2 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death december 12, 2008 **Physician** 6:40 PM M James McKenzie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec 21, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 68 219-34-7779 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Prince George'e Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 9211 Stuart Lane USA Funeral unk 12. Was Decedent Ever in U.\$1nk
Armed Forces?

1 □ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 📉 No 2 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD Southern Maryland Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🗓 Other (Specity) in state State Anatomy Board 655 W. Baltimroe Street Baltimore, MD 21201 Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia with Rupirobon Bilakral **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) Division of Vital Records. P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 1 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 10055 120 Dec 12 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1329 Southern Everyne Ke whard PArmere SE Suck 310 Washington DL 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Box 68760.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	tate of Maryland				Mental Hy	giene 🕕 🗍	8 40914
			Registrar		Certi	ficate of L	Death		Reg. No.	
	Physici	, 200	Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death
	Physicia /Medic		Many No	roc S				12	1 -	maga1 100mm
	Examin		4a. Facility Name (If no institution, give street		4	b. City, Town, or	Location of Death		4c. County of I	
			Riverview He	alth Ce	, 60	FSS	PX		Baco	himore count
_	Funeral	e a	5. Social Security Number 6. Sex	7. Age (In yrs. Ia		f Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9	Birthplace (State or Foreign
	Director		220-22-9095 10M	2× 83	Yrs.	fonths Days	Hours Min.	(Month, Da	3-192	Country) MANY/AND
_			Usual Residence of Decedent				l	17	1123	1000
	/lanc		10a. State 10b. County	10c. City,	Town or Locat	tion				10d. Inside City Limits
	Man	jo	MO BALLIN	and E	sex	Č				1 ☐ Yes 2 ▼ No
	tha 28a	Je.	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	with	۵	T Carlo			-2	2 1		; ) ( Z	3
	eath	Funeral Director	J Castern 181	Was Decedent Ever in U.S	13 Wa		ispanic Origin? (Sp	acity Vas or No	14 Bace -	American Indian,
	er d	Ē	THE MAINE CHAIG	Armed Forces?	if Y	es, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, etc.
9	s aft	by F		1 □ Yes 2 2 No If Yes, Give Year or Dates:	1 🗆	Yes 2 No	Specify:		Specify:	White.
3	hour	å F	/		160 Decedor	t's Usual Occupa	ation.		1Ch Kind of Busin	001/11
,	"nai	Completed	15. Decedent's Education (Specify only highest grade co		(Give kin		during most of won	king	16b. Kind of Busin	ess/industry
Z	withir iene. than	E D		College (1-4or 5+)	1				OUL	HOME
V	led v lygie her t		12		/ 17	mem		- 1000 - 1 1 10 - 1 11		7.1.2
	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. In dicher than "naturel", or items 23a or 28a-f show event, the Madral Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	T	OWNI	,		ie (First, Middle,	Maiden Sumame)	
<u>8</u>	should be nd Mental n markad o	2			1	7	UNK			
0	2 sho and is mu		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	Address (Street a	and Number or Ru	ral Route Number	er, City or Town, Sta	ite, Zip Code)
Ξ.	and alth		Mary F. Norris-	Daughter	223	5. (	srund	4 00	6. BA1.	to MD 21224
ח	as 1 of He of He fiterr		20a. Method of Disposition		ace of Disposition	and ar ather alan	0.1	Date	20c. Location - Cit	
Dallillo			1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	10 m 10 mm.	est Ceny	Lui 12.	- 19-08	Balto	Mondans
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		22. N	lame and Addres	s of Facility	7, 1 0 0	10 5	com House
Ö	permit. Departr Importa any inj		10/m/1200		To	sepl 1	V. ZANA	1120 -	Pald	Maryland un House 4/22/24
			23a Part Entermadease or complicati	one that caused the death	Do not enter t	the mode of dvin	a such as cardian	or recoiratory as	DA/10 /	Approximate
			23a. Part1. Enter the disease, or complicati shock, or heart failure. Ust only one c	ause on each line.	DO HOL BIRES (	ine mode or dying	g, such as calciae	or respiratory at	1631,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Colon C	encer					
	/Medical		resulting in death)	Due to (or as a consequ	ence of):					
	Examiner		Sequentially list conditions b	Metautat	re liv	rev Co	nen.			
	7 / 7	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c	Due to (or as a consequent	ence of):					
	ansi	Examiner	Cause (Disease or injury that initiated events							
ĵ	be axecutad		resulting in death) Last	Due to (or as a consequent	ence of):					
	cata be axecutad	cal	d							
00	ificata g physias the	0								
מכ	ndin use a	Physician/Me		If yes, outcome of pregnan					23d. Date of	f delivery
Ď	eath atter	cial	in the past 12 months?	1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of de		topic pregnancy ther (specify)			Month	Day Year
j	he d r the ched	ysi		9□ Unknown		(420)/				
Ľ	The law requires that the death certific ta has been signad by the attending p age 2 should be detached for use as		Part II. Other significant conditions contrib	uting to death but not resul	ting in the unde	arlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
cords,	signa signa d be	l by		•		, , ,		1 🗆 )	res 2 XNo 3	Probably 4 Unknown
5	neen s	ted							2 2 2 40 0 0	
์ บ	2 2 2	ple						24a. Was		e autopsy findings available r to completion of cause ol
ב	sician: The law s certificata has b firector, page 2 s	Completed							rmed? deat	
אוומ	an: rtiflica stor, a	0	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·			26. Place of Dea			
	ysic is ce direc	0 B	examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 DOA Othe	er: 4 Nursing H	ome 5 Resid	dence 6 Other (	Specify)
5	g Ph arth eral	n: T		8a. Date of Injury	28b. Time of	28c. Injury Work			now injury occurred	
5	th.: Aft	ertification;	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
VISIO	Atter dea ctor y tha	fice	3 Suicide 6 Could not be	8e. Place of Injury - At hor	ne, farm, street	. factory, office		28l Location (S	Street and Number of	or Rural Route Number,
5	or after	erti	4  Homicide	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov	vn, State)	
	pita ours eral filled	0	29a. Certifier 1 Certifying Physicia	an: To the best of my know	uladas dasth a	novernel of the time		and due to the		of the stand
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he complately filled in by the funeral director, page	edical	(Check only 2 Medical Exeminer:	en: To the best of my know On the basis of examination and manner stated.	on and/or inves	stigation, in my op	oinion, death occur	red at the time,	date and place, and	due to the cause(s)
	thin the mpla	Med	29b. Signature and tall of certifier	and mainter Stateu.		29c. License	number		29d. Date signed (N	fonth Day Year)
	Z N D		255. Signature and this of definer	~.5	)			}	Lou. Date signed (N	d a
				14.4		00	4/5(00	1	12/18	108.
	)		30. Name and address of person who comp	7	23a) (Type, Pri	nt)		0		
			Jebastian Ic		73 E	audern	105517	n 1501	timore	21227
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Tre Angula	A. C. C. C. C. C. C. C. C. C. C. C. C. C.				
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21208

1 ☐ Yes 2 No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

**OWNER** 

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

LEAH

14. Race - American Indian, Black, White, etc.

PAPER HANGER/PAINTER

MOSTOVAYA

Specify: WKITE

Juld be filed within 72 hours after death with the Maryland Mental Hygiene.
rked other than "natural", or Items 23a or 28a-f show rked other than "natural", or items 23a or 28a-f show tic event, the Medical Exacting regat be notified at Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

MD

11. Marital Status

Circle

College (1-4or 5+)

NISMAN

204 GLENN ELLEN COURT

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Never Married 2 📈 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

NISSAL

17. Father's Name (First, Middle, Last)

Director

Funeral

Completed by

Be (

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

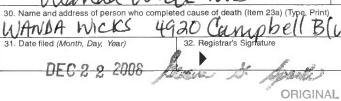
Division of Vital Records. P.O. Box 68760,

2 shou h and M is ma rauma		19a. Informant's Name/Relationship (		T	(Street and Number or R				
and lealth m 27 her tr		ALLA NISMAN / WI	· <del>-</del>		N ELLEN CIR				
Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition  1 🛱 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State   D / I T	ace of Disposition ( <i>Nam</i> metery, crematory or ot IMORE HEBRI	e of her place) EW CONG 12/ <del>2</del>	19	BALTIMOR		
permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is ma any Injury or other trauma once.		21. Signature of Funeral Service Licen	see		Address of Facility REISTERSTOW	SOL LEVINS N ROAD - P			
Physician		23a. Part1. Enter the disease, or compandot, or heart failure. List only Immediate Cause (Final	one cause on each line.	. Do not enter the mode	e of dying, such as cardia			Approximate Interval Between Onset and Death	
/Medical Examiner		disease or condition resulting in death)	a. Sinck (C Due to (or as a consequ	ence of):	4766-			1400	
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b						
ate be exe hysician ar he burial-l		Due to (or as a consequence of):							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 Ectopic pr			23d. Date of d Month	elivery Day Ye ar	
quires that the signed by uld be detac	þ	Part II. Other significant conditions of	contributing to death but not resu	llting in the underlying ca	ause given in Part I.	23e. Did tobac		to the cause of death?  Probably 4  Unknown	
The law re ate has bee page 2 sho	Completed					24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of	
sian: ertific ctor,	Be (	25. Was case referred to medical examiner?				eath (Check only one)			
nysic ais ce dire	10	1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DC	Other: 4 \sum Nursing	Home 5 sesidence	e 6 ☐ Other (Specify)		
nding Phath.	ation: 1	27. Manner of Death  1 Shatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred		
al or Atte after des I Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		me, farm, street, factory	office	28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,	
e Hospita 24 hours e Funera detely fille	Medical (	29a. Certifier Certifying Pi (Check only one) Medical Exam	nysician: To the best of my knominer: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and pla- , in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)	
To th withir To th	Me	29b. Signature and title of certifier	phis	290	License number		Date signed (Mo	17, 2008	
1,2		30. Name and address of person who  Martin J. Edelma			ltimore, Md		0000	,,,=	
Sta	to .	31. Date filed (Month, Day, Year)	32. Begistrar's Signa						
Registr		DFC 2 2 2	2008	& done					
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			Registrar			Cer	tificate	OT L	Jeath			Reg. No	0.		
	Physici	an	1. Decedent's Name (First, Middle, Last)	010							2. Date of D Month		ay Y	er	3. Time of Death
	/Medic		William		onnor		4b. Cify, To		Location		Decemb		8, 200		10:30 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give stre	eet and number)					vs Po				o. County of I Baltim		
	Funeral		8029 A Shore Road  5. Social Security Number 6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of B			Birthnla	ce (State or Foreign
	Director		5. Social Security Number 6. Sex 1	1 2□F	87	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D March	ay, Year 5,19	21 M	countr aryl	and
	p _		Usual Residence of Decedent											140	Libert to Otto I Libert
	show	'n	10a. State 10b. County		10c. City, Tov									100	<ul><li>Inside City Limits</li><li>1 ☐ Yes 2 ☒ No</li></ul>
	he Ma	Director	Maryland   Baltimore		S	parr	OWS PO					10a C	itizen of Wha	t Countr	
	with t		10e. Street and Number 8029 A Shore Road				101. Zip C	212	219			rog. C	USA	ii Couriii;	y :
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(0	fter d riten	Fu	1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ N			_				ecify Yes or N Rican, etc.)		Black, \	White, etc	2.
036	urs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2	X No	Specify.				Specify:	Whit	e
2-0	72 hours "natural",	Completed	15. Decedent's Educat (Specify only highest grade co	ion nmpleted)	16	a. Deced	ent's Usual	Occupa done d	ation	at of worki	na	16b. l	Kind of Busin	ess/Indu	stry
21	i within 72 ho giene. r than "natui ir Medical	ld m	Elementary/Secondary (0-12)	College (1-4or 5-			ind of work O NOT use	retired	)		3				
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anc	be fi ntal h ed ot	Be	17. Father's Name (First, Middle, Last)  Patrick O'Connor							a Aga		s, maidei	n oamame)		
Baltimore, Maryland 21215-0036	id 2 should be filed ith and Mental Hygi Ith and Mental Hygi 27 is marked other Traumatic event, II	Ĕ	19a. Informant's Name/Relationship (Type.	Print)	19	h Mailin	Address (	Street a			al Route Num.	ber City	or Town. Str	te. Zin C	Code)
Ma	id 2 s Ith ar 27 is 27 is		Raymond O'Connor	son											d 21219
ā,	f Hea		20a. Method of Disposition		20b. Place cemet	of Dispos	ition (Name	of of	0)	Dece	ate	20c. L	_ocation - Cit	y or Tow	n, State
9	Page: ent o nt: If ry or		1 M Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State			1 Memo			2, 2		Mid	dle Ri	ver,	MD
Ħ	mit. F partm sortar Inju		21. Signature of Funeral Service License	2	0.0	22.	Name and	Addres							
ä	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		Inthony (	onnel	lly	71	10 So.	llei	rs Po	int I	me Of I	Dund	alk,MD	<b>.</b> 21	222
	4		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	tions that caused	the death Do	o not ente	r the mode	of dyin	g, such as	cardiac o	or respiratory	arrest,		A	Approximate nterval Between
No.	Physician		Immediate Cause (Final disease or condition	Boni	Can	A 0			ate		4			(	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence	e of):									
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,09						,									
Box 687	ficate physics the b	Physician/Medical	d												
X	eath certific attending p for use as i	n/M	IF FEMALE: 23c. Was decedent pregnant 23c	. If yes, outcome	of pregnancy								23d. Date of	f delivery	/
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at			Ectopic pre  Other (s <i>pe</i>		у				Month	D	ay Year
P.O.	that the deneed by the detached	hys	9 ☐ Unknown	9 Unknown											
	ires that signed I	by P	Part II. Other significant conditions contri	buting to death bu	ıt not resulting	in the un	derlying cau	ise give	en in Part	l.					cause of death?
ord	w require been si should b	ed									1 🗆	Yes 2	2 12 10 3[	] Probal	bly 4 Unknown
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Ĕ	ding Ph n. After thi funeral	io		28a. Date of Injui (Month, Day	(Year)	. Time of Injury	M 28	c. Injury	yat ⟨? Yes 2□		28d. Describe	how inju	ury occurred		
isi	Attend death ctor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	iry - At home	farm stre			res 2		28f Location	(Stroot a	and Number	or Bural i	Route Number,
Division of Vital Records,	pital or Attencours after deathers after deatheral Director: filled in by the	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)	iarri, ou a	or, ractory,				City or To	wn, Stai	te)	), / IG/G/ /	Todic Hamber,
	spita nours neral / fillec		29a. Certifier 1 CertifyIng Physic												
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exeminer one)	r: On the basis of and manner sta		and/or inv	estigation, i	in my o	pinion, de	ath occurr	red at the time	e, date ar	nd place, and	due to t	he cause(s)
	To th withii To th	Me	29b. Signature and title of certifier	. /)	^		29c.	License	e number	;	2	29d. D	ate signed (	Aonth, Da	ay, Year)
			Manda M	CKL IV			$\mathbb{D}$	00	36	34	3	1	2/20	108	
	10		30. Name and address of person who com	pleted cause of de	eath (Item 23a	a) (Type, F	Print)	1	1,11	1.	11	1	nan	~	1236
	10		WANDA WICKS 4	420 Ca	niph	ell	B(10	L .	WI	ute.	<i>Maurs</i>	n,	IND	-2	1426

State Registrar

DEC 2 2 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Theresa Payne Jean 19,2008 DEC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany 8. Date of Birth (Month, Day, Year)
July 20,1973 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 X F Days Hours 212-92-0807 35 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Colgate 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7900 Wynbrook Road 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Me Elementary/Secondary (0-12) College (1-4or 5+) 9 years N/A Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Payne Sr. Mary Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Berlin Step-Father 7900 Wynbrook Road, Colgate, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 24, 2008 4 □ Donation 5 □ Other (Specify) <sup>22</sup>. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Petrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4825 **Physician** /Medical equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and I for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 - No 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 2 ER/Outpatient 3 DOA Inpatient 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Funeral Director: 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) 30. Name and address of person who completed BISHOP WARSH DR. CUMBBRUND, MD 21502 WAGONER 925 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2M December Goldie Parker 2008 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Baltimore Teneral MRY/and If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F MD 57 Director 9-13-1951 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event. 1406 W. Franklin Street 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Bus Aide Baltimore City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bertha Flowers Bernard Parker
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavern Flowers - Sister 910 Whitelock St. Apt. B Baltimore, Md. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-23-08 Catonsville, Md 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rdromyou Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the a page 2 should be detached þ Completed certificate 2 Be P

/Medical Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 funeral director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the

4

Medical

Certification:

(Check only

29b. Signature and title of certifier

Registrar

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 5☐ Other (specify) 9☐Unknown	Month Day Year
art II. Other significant conditions o	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 1 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5. Was case referred to medical	26. Place of	Death (Check only one)
exam/her? 1 ☑ Yes 2 ☐ No	Hospital: 1   Inpatient 21 ER/Outpatient 3   DOA Other: 4   Nursin	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1  Natural 5  Pending 2  Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Joseph Price Decem 162008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A If Under 24 Hrs. (In vrs. last birthday Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 213-28-2264 82 Jul 25, 1926 Maryland Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be rictified at 1 Yes 2 □ No Director N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 3606 Woodlea Avenue 21214 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 238 any injury or other traumatic event, the "Modical Examiner must any injury or other traumatic event, the "Modical Examiner must app. once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1945 1 ☐ Yes 2 🙀 No Specify Black 3 Widowed 4 Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Liquor Company Foreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Price Helen Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 Woodlea Avenue Baltimore, Maryland 21214 Myrtle Price 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/08 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Sign ture of Funeral 6. vice, is niee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician uremi disease or condition resulting in death) /Medical Due to (or as a consequence of) renal disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit per The law requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical use as the signed by the attending I IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been s page 2 should pulmonai 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy performe Yes 2 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 1 ☐ Yes 2 No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director; After the completely filled in by the funeral funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 3 ☐ Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Johna parna

D0062735

who completed cause of death (Item 23a) (Type, Print) Name and address of person

32. Registrar's Signature

Loch Raven Blvd. 5601

Baltimore, MD 21239

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			For State	tate of Maryland /	Department of Health	, 0	iene	10000
			Registrar		Certificate of Deatl	h Re	g. No.	40920
П	Physici	an	Decedent's Name (First, Middle, Last)	$\circ$	D 40- 1	2. Date of Death Month	n Day Year	3. Time of Death
	/Media		Stanley	MAUL	POTRZUSK,	Dec	20,2008	4:10 p.M
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5			321 S. EA	st Avenue				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day,	Year) 9. Birthpla	ce (State or Foreign
	Director		216-14-7112	<sup>2□F</sup> 85	Yrs. Months Bays Hours	Oct 14	1923 MA	CY MIND
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	*		T	
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aĦ			21. Signature uneral Service Licensee		22. Name and Address of aci			
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			23a. Part 1. Enter the disease, or complication shock, or heart failure. Live only one car	ons that caused the death. Do	not enter the mode of dying, such a	as cardiac or respiratory arre	st. A	pproximate
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	Hos 24 h Fun etely	dica	Medical Examiner:	On the best of my knowledge On the basis of examination ar and manner stated.	e, death occurred at the time, date a nd/or investigation, in my opinion, de	and place, and due to the car eath occurred at the time, dat	use(s) and manner as stat te and place, and due to th	ed. e cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	and manner Stateu.	29c. License number	an	d. Date signed (Month, Da	v Vear)
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	~		John K. Du	Pton, MD	10018	01 00	sempor 20,0	2008
•	1.7		30. Name and address of person who comple	eted cause of death (Item 23a)	(Type, Print)	2 841.	40.0	
			31. Date filed (Month, Day, Year)	132 Registrar's Signature	M-BOYVIEW CO.	L 13a.67/more	M1) 21	224
	Stat Registra		DFC 2 2 2008	Sz. negistiai s Signature	parts.			
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DHMH 17 Rev 1/2001

amend #26 Per Phy G886 12/22/08 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician /Medical 4a. Facility Name (If n 4b. City, Town, or Location of Death 4c. County of Death Examiner aboe Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□ M 2**X**F Min. Hours 212-42-600 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, I'm Madical Evantier Trust be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 **(**es 2 **□** No timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code vanhoe Avenu Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Scondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Mo 20a. Method of Disposition HO.MD2 Baltimore, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Source Licensee Mo1553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Kidney < lyear **Physician** Disease /Medical Due to (or as a consequence of): **Examiner** < lyear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Years K B law requires that the death certificate be exec Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Discaso 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nis certificate has been s director, page 2 should i Completed Mistory 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate Anemia **Division of Vital** 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 XNo Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0053652 12-17-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADHIKA 33 rd 200 Baltimore, Street, 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 2008 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

					tment of Health and M	lental Hygie	ne <sub>2 0 D 2</sub>	1.0025
			1 - State Registrar	Cert	ificate of Death	Reg.	No. 4 U U O	1006
	Physici	an	Decedent's Name (First Middle, Last)	3 Ral	2	Date of Death     Month	Day Year	3. Time of Death
	/Medic		Paul	V 1 -012	mason		9 2008	5:40 AM
	Examir	er	4a. Facility Name (If not institution, give street and number ST. AGNES HOSPOTAL	r) 4	4b. City, Town, or Location of Death  BALTINURE.		4c. County of Death	1 .
	Francis			Age (In yrs. Jast birthday)	If Under 1 Year   If Under 24 Hrs.	8 Date of Birth		1A
п	Funeral Director		215-74-9622 18M 20F		Months Days Hours Min.	8. Date of Birth Month, Day, Ye	ar) Cou	place (State or Foreign ntry)
	ъ		Usual Residence of Decedent			July 31, 1	1-1100	arytend
	arylan show	-	10a. State 10b. County	10c. City, Town or Local	ition			10d. Inside City Limits
	8a-f	ecto	ma. ~//	$\square$	altmail			1 Xes 2 No
	a or	ā	10e. Street and Number	G+ Aptz=	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the than "natural", or items 23a or 28a-f show after than "natural", or items 23a or 28a-f show aft, the Macinet Extrainer must be inciffied at	<b>Funeral Director</b>	11. Marital Status 12. Was Decede	t Ever in U.S. 13 We	as Decedent of Hispanic Origin? (Spo	noify Voc or No	14. Race - Ameri	an Indian
တ	ifter d irrer		Armed Force 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2	37 If Y	es, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
<u>8</u>	raf",o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date	1 1	Yes 2 No Specify:		Specify:	SIACK
21215-0036	72 hc 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occupation nd of work done during most of worki	16b	. Kind of Business/In	dustry
12	vithin sne. than '	Idm	Elementary/Secondary (0-12) College (1-4c	life DO	NOT use retired)	10	en attra	
р Б	filed v Hygic ther t	ပ္သ	17. Father's Name (First, Middle, Last)		18 Mother's Nano	e (First, Middle, Maid	Ion Surnama)	cein
	d be ental ked o	To Be	Pare H. Robinson	•	Mari	4	PILLER	_
яrУ	should be ind Mental marked c	Ĕ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street and Number or Ru a			
	1 and 2 Health a em 27 is ther tra		Gail Y. Kobinson	WIFE 360	IN Franklins	~ ~ ~ ~	<u> </u>	nd. 21229
altimore,	r i o		20a. Method of Disposition	20b. Place of Dispositi	ion (Name of District of Other place)		ocation - City or To	
Ĕ	Pages ment of ant; If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Metro	Cremater 12-3	208 (	atons	nile, mD.
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	22. 1	Name and Address of Facility	05 W. F	Tankle	ni of
	<u> </u>		falley M. Cy	Elece No	ancy m. Wal	lace F.S	· Bali	6. ma, 21239
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not enter the line.	the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	any atta	rasclirosis			esso
	Examiner		Unatolor	s a c lose (jence of):	_		K	)
		Je.	Sequentially list conditions, b	s it consequence offy	10-50			The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa
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9 ×	ding I	Me	IF FEMALE:	o of prognance				
Box	eath certific attending p for use as	sian	The past 12 months:	2 ☐ Fetal death 3 ☐ E	ctopic pregnancy Other (specify)		23d. Date of deliver	ery Day Year
0	ine law requires that the death certil ate has been signed by the attending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Fregran 9 ☐ Unknown 9 ☐ Unknown		other (specify)			,
J	s mar ned b	by Pl	Part II. Other significant conditions contributing to death	but not resulting in the unide	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Vital Records,	quire en sig uld ba	q pa	Pericardial offusio	~ 2° te ky	perleveres	1 ☐ Yes	2 ☐ No 3 ☐ Prot	pably 4 Unknown
ပ္သ	as be	Completed	and stage renal	disease		24a. Was an	24b. Were auto	psy findings available
ř	the I	E				autopsy performed? 1 ☑ Yes 2 ☐ I	?   deatb?	mpletion of cause of
<u> </u>	ician; the law certificate has ector, page 2 s	Be (	25. Was case referred to medical examiner?		26. Place of Death		12163	2 🗆 140
0	rnysi this o	၉ ့	1 Yes 2 No Hospital: 1 Inpa				6 ☐ Other (Specif	y)
ב	After funer	ertification;	27. Man of of Death 1 ✓ Natural 5 ☐ Pending (Month, L	jury 28b. Time of ay, Year) Injury	Work?	28d. Describe how in	jury occurred	
Division	death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of I	njury - At home, farm, street,	M 1 Yes 2 No	Of Location /Caraca	and Months and D	
	after after Dire	ert	4 Homicide determined building,	tc. (Specify)	, idoloty, office	City or Town, Sta	and Number or Rura ate)	I Houte Number,
	hours hours inera	Salc	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, death or	ccurred at the time, date and place, a	and due to the cause	e(s) and manner as s	tated.
-	To the nospiral or Attending Prysician; within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, to	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	of examination and/or investated.	stigation, in my opinion, death occurre	ed at the time, date a	and place, and due to	the cause(s)
ŀ	To Corr	≥	29b. Signature and title of certifier	)- \	29c. License number		Date signed (Month,	
			Filler & Olden,	Ch.D.	204968	Dees	miles 19,	2008
	2		30. Name and address of person who completed cause of	death (Item 23a) (Type, Prir	DO4968 ENES HOSPIVAL,	BAMMILLE	ELAN	7/290
	Stat	e		rar's Signature	CIC BHOSPITAL,	MEIMOR	- ( ) S	4321
	Registra	_	DEC 2 2 2008 A	100	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA			
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			For State Registrar	State of Mai	ryland /	•			lealth a Death	and M		giene Reg. No.	2008	4092
	Physici		1. Decedent's Name (First, Middle, Las	)) \		120	sen	BLA	TT!	JZ	2. Date of Dea Month	Pay Pay	Year 7000	3. Time of Death
-	/Medio		4a. Facility Name (If not institution, give	street and number)					Location of		700	4c. (	County of Death	1
j J	LXaIIII	eı		Bayuren	Medic	el (nol-	2	sal.	Hmo	ر المعرار			N/A	
	Funeral Director		5. Social Security Number 6. Se 215 – 16 – 7555		(In yrs. last t		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Date 04/16/	1923		nplace (State or Foreign untry) NJ
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	the Marylar 28a-f show	Director	MD BALT				BALTI					40- 0''		1 □Yes 2 No
	a or 3	ä	10e. Street and Number	110			10f. Zip	2120	10				en of What Col	antry?
	sath is 23	eral	5 POMONA NORTH,	<b>押∠</b> 12. Was Decedent Ev	ver in IIS	13 \	Mas Decer			gin2 /Sn	acify Ves or No		4. Race - Amer	ican Indian
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medicel Exacilizational by Louising at a content traumatic event, it is Medicel Exacilizational to the content and an exact that the content is a content to the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and the content and	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Dayes 2 □ No If Yes, Give Year or Dates:		V	fYes, spec		Specify:	i, Puerto	ecify Yes or No Rican, etc.)	}	Black, White	
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16	a. Deced	dent's Usua kind of wo	al Occup	ation during mos	t of worki	na	16b. Kin	d of Business/I	ndustry
21215-0036	2 should be filed within and Mental Hygiene. is marked other than "aumatic event, It Men	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)		ANAGE		during mosi i)			US	GOVERN	MENT
pu	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	~ 0 0 5	a a more and a second		0.5	.			(First, Middle,	Maiden S		F: 1
<u>ya</u>	should be fi and Mental H s marked ot umatic ever	2	JOSEPH K	ROSE	MBLATT		SF			4ILY			SCHIPP	
, Maryland	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (7 DORIS ROSENBLATT		15		•	,			BALTIM		MD 21	ip Code) 208
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition  1			tery, cren	sition (Nar natory or o FRIEN	ther plac		12/1	9/2008	BAI	cation - City or T _TIMORE	, MD
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	utter		22			ss of Facilit					S., INC. E, MD 21208
	Physician /Medical Examiner	r	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	consequence	(UC) e of):		_	g, such as	1		rrest,		Approximate Interval Between Onset and Death
,8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.	consequence consequence	Fail	love							Hyders
O. Box 6	that the death certificated by the attending potentials are detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal dea		Ectopic p Other (sp		у			2	3d. Date of deli Month	very Day Year
ds, P.	uires that signed b	by	Part II. Other significant conditions of	ontributing to death but	not resulting	in the ur	nderlying c	ause giv	en in Part I.		23e. Did t		se contribute to	the cause of death?
al Records,	hysician: The law requir his certificate has been s I director, page 2 should	Completed									24a. Was autop perfo 1 □Yes		prior to death?	topsy findings available completion of cause of 2 □ No
Vit	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Deat	(Check only o	ne)		
of Vital	Phys this	은	1 Yes 2 No 27. Manner of Death	1 LZ Inpatien		Outpatien  Time of	t 3 🗆 DC		4 🗆 NU				Other (Spec	cify)
Division	fing L. After fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Injury	M		yat ⟨? Yes 2□	No	28d. Describe I			
Divi	P He de		4 Homicide determined	building, etc.							City or To	vn, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)	ysician: To the best of liner: On the basis of and manner state	examination .		vestigation	ı, in my o	pinion, dea			date and	place, and due	to the cause(s)
_	To the within To the comple	Σ	29b. Signature and title of certifier						e number			29d. Date	signed (Month	n, Day, Year)
	Ve		30. Name and address of person who	heet mo	ath (Item 23a	a) (Type,		165	.00	0		Dec	17	7008
	<u> </u>		Aleigail Lenhart	m.D. 40	1408	Ciste	in	Au	e B	athi	noise n	DIN	2177	4

State Registrar

DHMH 17 Rev 1/2001

Accigail Lenhart M.D. 4940 Eastern
31. Date filed (Month, Day, Year)
32. Registrar's Signature

DEC 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Violet K. Stahl Ž0, РМ December 2008 7:35 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours Min 218 16 3573 87 April 1, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b Counts 10d. Inside City Limits Maryland Baltimore White Marsh 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10503 Vincent Rd. 21162 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Worker Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Kight Magnolia Ball 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan H. Stahl (Son) 10503 Vincent Rd. White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Red House Lutheran Cem. 12/23/2008 Red House, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old <u>Fastern</u> Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home P.A 1407 old Fastern Avenue Esse 23a. va 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str ck, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular erebral Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

o. Δ. Records, of Vital Division Hospital

or Attending within 24 hours after death.

To the Funeral Director:

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Its Madical Examinat mattle inclined

12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

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200

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Black

DEC 2 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 North Charles St

32. Registrar's Signature

the

filled in by

DHMH 17 Rev 1/2001

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061199

29d. Date signed (Month, Day, Year)

Dec. 21, 2008

Suite 209 Touron MD 21204

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g886 12-22-08 vt. State of Maryland Department of Health and Mental Hygiene

For

40925

Registrar	Ce	ertificate of Death	Reg. No.	
Physician /Medical  1. Decedent's Name (First, Middle, Last) Sarah	Elsie	Seaton	2. Date of Death Month Day 12 14	3. Time of Death 2008 12:00a <sup>M</sup>
Examiner  4a. Facility Name (If not institution, give streether)  Blue Point Nursi		4b. City, Town, or Location of Death Baltimore	4c. Count	ty of Death
S Control Control Number   C Control	7. Age (In yrs. last birthda		8 Date of Birth	9. Birthplace (State or Foreign
	<sup>2</sup> X <sup>F</sup> 103 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 05 29 05	Country) VA
0	10c. City, Town or	ocation		10d. Inside City Limits
MD NA	Balti	more		X□Yes 2□No
10e. Street and Number	n Stroot	10f. Zip Code 21217		What Country?
MD NA  10e. Street and Number  1708 North Payso  11. Marital Status  1 Never Married 2 Married				ace - American Indian,
1 Never Married 2 Married	1 Yes 2 No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ack, White, etc.
Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Speci	DIACK
To an attendant with the Maryland of Mental Hygiene.  MD NA  10a. State 10b. County  MD NA  10a. Street and Number  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708 North Payso  1708	ompleted) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king 16b. Kind of 8	Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	ducator		ty Schools
D S S S S S S S S S S S S S S S S S S S			e (First, Middle, Maiden Suma	ime)
Major Smith  19a. Informant's Name/Relationship (Type)			Grimes	
W RELE Fleio S Mackey-F		ling Address (Street and Number or Ru Arbutus Ave, E		
20a. Method of Disposition  1 XBurial 2 Cremation 3 Rem  4 Donation 5 Other (Specify)  21. Sharature of Funeral Service Licensee	20b. Place of Disposariatery of	position (Name of	Date 20c. Location	- City or Town, State
20a. Method of Disposition  1 XBurial 2 Cremation 3 Rem  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	king Me	morial Park $\frac{12}{2}/2$	22/08 Woodla	awn, Md
21. Shratut of Funeral Service Licensee	M- ma	archand Address of Facility		01015
	1 - 400/ 1/11	300 Wabash Ave,		
23a. Pa /l. Enter the disease, or complicated by ock, or heart failure. List only one limediate Cause (Final			or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical / Sease or condition resulting in death)	End-Stage Al-he; Due to (or as a consequence of):	mers bementia		
Examiner Sequentially list conditions b				
any, leading to imhediate	Due to (or as a consequence of).			
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3	☐Ectopic pregnancy		ate of delivery Ionth Day Year
The law requires that the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death reduces the death re	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)		lonth Day Year
Part II. Other significant conditions contril	outing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use cor	ntribute to the cause of death?
w requires the vertical state of the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as the peak signed as			1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
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25. Was case referred to medical examiner?	pital:	1 Others 1	h (Check only one)	
O 1 ☐ Yes 2 ☐ No Hos	1 ☐ Inpatient 2 ☐ ER/Outpati		ome 5 Residence 6 Ot 28d. Describe how injury occu	
DIVISION OF VITAL RECORDS,  1 a later death.  2 a stler death.  2 a later death.  2 a later death.  3 a Director: Alter this certificate has been signed by the funers that the drawning Physician: The law requires that the drawning Physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the drawning physician: The law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires the law requires that the law requires that the law requires that the law requires that the law requires that the law requires the law requires the law requires the law requires that the law re	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe flow injury occu	11100
N ## 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Num City or Town, State)	nber or Rural Route Number,
Homicide  Letting a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c				
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29b. Signature and title of certifier	^	29c. License number	29d. Date signe	ed (Month, Day, Year)
► NSRajapahsem		000574		15/08
30. Name and address of person who comp	oleted cause of death (Item 23a) (Type 25 Main St., Suih	e 200, Reisterston	n, MD 21136	) ,
State 31. Date filed (Month, Day, Year) Registrar  DEC 2 2 20	32. Registrar's Signat <del>ure</del>	Garles.		

08-09381 Kathy Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cathy Smith		ment of Health and Mental Hyg <i>ïcate of Death</i>	Reg. No. 2008 4092
Physician/	Decedent's Name (First, Middle,Last)		Date of Death 3. Time of Death
Medical Examiner	Kathy Crystal  4a. Facility Name (if not institution, give street and number)	Smith  4b. City, Town, or Location of Death	Month Day Year 0058 hrs December 14, 2008 0058 hrs
	Sinai Hospital	Baltimore	10. 555, 6. 255
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last		Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	213-94-6528 1 M 2X F 44		08 10 64 Country) MD
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits
	MD NA	Baltimore	1X Yes 2 No
234M the Maryland a or 28a-f show tiffed at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h the N	5631 Belle Ave	21207	U.S.A.
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 X Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	
fter der F, or i er mu	1 Yes 2X No 3 Widowed 4 Divorced If Yes, Give Yeer	1 Yes 2X No specify:	Specify: Black
ours aft		Sa. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired	done 16b. Kind of Business/Industry
36 in 72 h lian "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na	Graphic Arts	Book Factory
5-0036 ed within 72 hour ed within 72 hour offer than "natu the Medical Exan Completed	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	William Walker	Naomi Ta	ylor
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		19b. Mailing Address (Street and Number or Run	
mud 2 sho and 2 sho lealth and tem 27 is tem 27 is traumati		5631 Belle Ave, Bal	timore, Md 21207 ate 20c. Location - City or Town, State
Baltimore, permit Pages I an Department of He- Important: If ite	TA Bullar 2 Cremation 3 Nemoval nom State	matory or other place)  g Memorial Park 12/	20/09 Moodlawa Md
Baltin permit Pa Departmed Importan injury or	Donation 5 Other Specify: K1no	22. Name and Address of Facility. March F/H West	20/08 Woodlawn, Md
ii ii De a	Gerome a. Thompson	4300 Wabash Ave,	Baltimore, Md 21215
Physician / /Medical	23a. Part I. Enter the disease, or complications that caused the death. Define. List only one cause on each line.		Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intox Due to (or as a consequence of):	ication and cocaine use	Death
	Sequentially list conditions, b		
iner	if any, leading to immediate Due to (or as a consequence of):		=
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Exaction	d.  X UNPENDED	8a-f, per ME g886 12/30	0/08 TT
box 68760, the death certificate be executly the attending physician and ched for use as the burial - raphysician/Medical	IF FEMALE: 23c. If yes, outcome of pregnar		23d. Date of delivery
Sox 6876 death certificate e attending phy for use as the I	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnanc	Month Day Year
Box 687 death certifice the attending p of for use as th	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other (Specify)	
ires that the de signed by the detached f	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
S, P.C uires that n signed d be deta ed by		-	1 Yes 2 No 3 Probably 4 Unknown
cords, aw requin has been s 2 should t			24a. Was an autopsy prior to completion of cause of death?
tal Records, cian: The law requires certificate has been signetor, page 2 should be Be Completed			1 Yes 2 No 1 Yes 2 No
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 VEI	26.Place of Death (Check onlean Other)  R/Outpatient 3 DOA Other, Nursing R	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated by Pertification: To Be Completed by P	27. Manner of Death 28a. Date of Injury 28	Bb. Time of Injury 28c. Injury at Work? 28	d. Describe how injury occurred
Division c spital or Attending hours after death, neral Director: Aft filled in by the fun Certification?	Natural 5 Pending Fd 12/14/08 F	Fd 0058 hrs 1 Yes 2 XNo un	nk
Divisior pital or Attend outs after death teral Director: filled in by the Certificatic	3 Suicide 6 X Could not be 28e. Place of Injury - At hom	e, farm, street, factory, office building, etc. 28	of Location (Street and Number of Rural Route Number, City or Town, State) Sinai Hospital altimore, MD
ospital hours lumeral ly fille	4 Homicide determined (Specify)  29a. Certifier A Continue Physician To the best of my knowledge.		
To the Hospital Within 24 hours To the Funeral Completely filled	(Check only one) 2 • Medical Examiner: On the basis of examination and	or investigation, in my opinion, death occurred at the	the time, date and place, and due to the cause(s)
Me is it is	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Calmit !	O.C.M.E.	December 14, 2008
R	30. Name and address of person who completed cause of death (Item 23 Zabjullah Ali, M.D. Assistant Medical Examiner	Ba) 111 Penn Street, Baltimore, MD 2120	1
State	31 Date filed (Month Day Year) 32 Registrar's Signature		
Registrar	DEG 0 0 2000 Ave.	Goarde)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 16, 2008 **Physician** Esther Simon 3:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 415 Spring Avenue Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 🗆 M 16, 93 Ohio 298-38-5380 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Lutherville 1 ☐ Yes XXNo **Funeral Director** 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 0 21093 415 Spring Avenue U.S.A. items 23a 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 🛛 X o Specify: Specify: White ð 3€Widowed 4 □ Divorced natural", Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Practical Nurse Private Duty 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 Is marked oth any injury or other traumatic event 90ce. 17. Father's Name (First, Middle, Last) Samuel Mitchell Clara Blaushild ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, MD Sandy Runyeon (Daughter) 415 Spring Avenue 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation ③ ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/08 Mt. Olive Cemetery Solon, Ohio 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burgee-Henss-Seitz 3631 Falls Road Ba Funeral Home Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due 1 Examiner diey discaso To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed?? 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \sum \) Nursing Home Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Namral 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Year) 32. Registrar's Signature State 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			Certificate of		Re	g. No.	4 1 1 2 4 0	
	Physici	an	1. Decedent's Name (First, Middle,	,				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin		John Dona  4a. Facility Name (If not institution,			4b. Citv. Town.	or Location of Dea		19, 2008 4c. County of Death	6:30 P <sup>™</sup>	
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	Funeral			. Sex 7. Age	(In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs		9. Birth	place (State or Foreign ntry)	
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-UUSO	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	a-f sh	ctor	Maryland Baltin	nore		Towson				1 □Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	ath w		615 Chestnut Av			2120			USA		
	items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,		
13-003B	ours after death with the Marylan ral", or items 23a or 28a-f show Examinat noust by notified at	þ	1 ☐ Never Married 2 💥 Married 3 ☐ Widowed 4 ☐ Divorced	1 Mayes 2 □ N If Yes, Give Year or Dates:	° Q41_45	1 □Yes 2 X No	Specify:		Specify:		
5	72 hours "natural", dicel Exe	Completed	15. Decedent's	Education		Decedent's Usual Occu	pation	. 10	6b. Kind of Business/In	nite dustry	
7	d within 72 ho giene. r than "natui r be Medicel	nple	(Specify only highest (Secondary (0-12)	College (1-4or 5+	)	(Give kind of work done life. DO NOT use retire	e during most of wo ed)	rking			
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<u> </u>	should be nd Menta marked matic ev	욘	John 19a. Informant's Name/Relationship	Snyder (Type Print)	19h	Mailing Address (Stree	Kathr		Borgerdii		
Z	nd 2 salth ar		Virginia E. Snyd			615 Chestnu				•	
ָר ב	is 1 a		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other pla	nca)		Oc. Location - City or To		
	Page nent o		1 ☐ Burial 2 🔣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State cify)		ic Cremator	i	2/08 G	len Burnie,	Maryland	
Dalimo	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.	<	21. Signature   Funeral Service   In	toerer	, , , , , , , , , , , , , , , , , , , ,	22. Name and Addr	ess of Facility Ineral Ho	me of Dula	aney Valley	Inc.	
			23a. Par 1. Enter ne disease, or co	mplications that caused t	he death. Do n				um, MD 21(	Approximate	
F	hysician		s/fock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition )  Which is the cause (Final disease or condition )								
	/Medical		diserise or condition resulting in depth)  a								
Ł	Examiner	L	Sequentially list conditions.	ns, b. ———————————————————————————————————							
11	sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
4	execu n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of	nsequence of):					
7	icate be executer physician and the burial-transit										
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	tth cel tendir r use	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 ☐ Ectopic pregnan	CV		23d. Date of delive	•	
5	the at	hysician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		5 Other (specify)			Month	Day Year	
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	nysic nis ce direc	70 B	examiner? 1 ☐ Yes 2 <b>K</b> No	Hospital: 1 ☐ Inpatien	t 2 ER/Out	patient 3 DOA Oth	or:		ce 6 ☐ Other (Specif	y)	
1	Ing P	ü	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. T	ime of 28c. Inju	ry at rk?	28d. Describe how	injury occurred		
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	or An after of Direction by	Certification:	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						l Route Number,		
- logica	spiral nours neral filled		29a. Certifier 1 X Certifying I	Physician: To the best of	my knowledge	death occurred at the t	ime, date and place	e, and due to the cau	ise(s) and manner as a	tated	
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t t	vithir comp	Me	29b. Signature and title of certifier	1 1		29c. Licens	se number	290	I. Date signed (Month,	Day, Year)	
			M Ami	by The	7	1)	25 20	5	December 2	22, 2008	
r	1141		30. Name and address of person wh	completed cause of de	ath (Item 23a) (	Type, Print)			· · · · · ·		
	1,		Anthony W. Ril 31. Date filed (Month, Day, Year)	ey, MD 670	N. Ch	arles St.,	Towson, l	Maryland	21204		
	Stat Registra	.~	DEC 2 2 200	8 January 1	o dignature						

State

ALLEN REILLY, M.D. 31. Date filed (Month, Day, Year) DEC 2 2 2008

29b. Signature and tity of Artifier

en

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 TOLL HOUSE AVENUE, D-1' 32. Registrar's Signature

Registrar

29d. Date signed (Month, Day, Year)

FREDERICK, MD.

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 12:20 A M Sidney Bowen Smith, Sr. 10 DECEMBER 12008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2□F Months 88 Maryland 7/14/1920 213-10-7207 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Woodlawn 1 ☐Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 6728 Brookmont Drive United States Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 "natural", or If Yes, Give WII Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 1 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery Production Jermit. Pages 1 and 2 should be filed w Jepartment of Health and Mental Hygier nportant; if Item 27 is marked other th it Injury or other trailmast. Stationary Engineer 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Wolff Hilroy H. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6728 Rrockmont Drive Woodlawn, MD 21207 19a. Informant's Name/Relationship (Type. Print)
Mrs. June N. Smith / Wife 6728 Brookmont Drive Woodlawn, MD 3altimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ites
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stive Spira 5 Days Physician disease or condition resulting in death) /Medical Due to o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transi tailure resulting in death) Last Due to (or as a consequence of) nding physician Box 68760. Physician/Medical the ! 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2000 2×K No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27.-Manner of Death 28b. Time of 28d. Describe how injury occurred il or Attending Fafter death. 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT-2438941 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union

Registrar

State

31. Date filed (Month, Day, Year)

32 Segistrar's Signature

2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 18,2008 2015P M **Physician** Frank E. Shuster /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Ctr. Harford Bel Air 8. Date of Birth (Month, Day, Year) 3 – 2 – 1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1☐M 2□ F Months PA 87 184-12-3897 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, if a Medical Examination to a notifical at Harford Bel Air 1X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 2005 Gumtree Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ≜Yes 2 □ NoWWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 5 + Engineer Alcoa and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary E. Hollinger Donald B. Shuster 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie W. Shuster- Wife 2005 Gumtree Terrace, Bel Air, MD 21015 permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 12-20-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton FuneralHome 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mmuhet disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine rial law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 🗌 Unknown o the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐Yes 2 ☐No Vital To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certified D0065827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Drive, Bel Air, MO 21014 Accelo Popoe 2 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Frank

00038003W

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** +00 K 11:13 р м 2 /Medical 4a. Facility Name (If not institution, give street and number, 4h. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 12 M 2 □ F Maryland Director Sept. 04, 1920 216-05-3481 88 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1831 Cook Farm Court 21122 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Resturant & Lounge Elementary/Secondary (0-12) College (1-4or 5+) Owner ortant: If item 27 Is marked other injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna M. Sheback Oscar C. Shook ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Shook 1831 Cook Farm Court, Pasadena, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If itel any injury or otl once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-20-08 Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 3204 Mountain Road, Pasadena, Maryland 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final renuor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nis certificate has director, page 2: autopsy performe 1 ☐ Yes 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐Yes 2☐Ño Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical (Check only one) and manner stated wre and title of certifier 21438 completed cause of death (Item 23a) (Type, Print) VX/ M 44 31. Date filed (Month, Day, 32. Registrar's Signature Year) State DEC 2 2 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Char	oma	as	6:30 p M						
)	Examir		4a. Facility Name (If not institution, give street and number)  Blue Point Nursing Ho	me, LLC		4b. City, Town, or		Death <b>Baltim</b>	ore	4c. County of D	eath N/A	
2.	Funeral Director		5. Social Security Number  223-36-3723  6. Sex 1 □ M 2 □ F  7. Age	(In yrs. last bird	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birth (Month, Day, Ye Oct 1, 1	9. E	Birthplace (State or Foreign Country) Virginia	
	Maryland a-f show ified at	ctor	10a. State 10b. County  Maryland N/A	10c. City, Towr	or Loc		altimore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the 3a or 28 st be not	al Dire	10e. Street and Number 1602 Moreland Avenue			10f. Zip Code	2121	6	10g.	lg. Citizen of What Country? U.S.A.		
036	should be filed within 72 hours after death with the Maryland rind Mental Hygiene. In arked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 Xes 2 Year or Dates:			Vas Decedent of Hi Yes, specify Cuba □ Yes 2□ <b>X</b> lo	spanic Origir n, Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. Black	
Maryland 21215-0036	within 72 ho iene. than "natul the Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-1)		Decede (Give k life. D	ent's Usual Occup kind of work done o O NOT use retired	ation during most o aborer	of working	168	p. Kind of Busine Privat	e Company	
land 2	lld be filed lental Hygi ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last)  Claude Thomas			18. Mother's Name (First, Middle, Maiden Surname)  Mary Coley						
Ž	and 2 shou ealth and M n 27 is mar ier traumat	-	19a. Informant's Name/Relationship (Type. Print) Annie Thomas	19b.		g Address (Street a				,	e, Zip Code)	
Ψ.	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Dopaţion 5 ☐ Other (Specify)	20b. Place of cemeter		sition (Name of natory or other place estern Cemet		Dat	e 200 2/20/08	: Location - City Balti	or Town, State more, Md.	
Balti	permit. Departr Importa any inju		21. Sig_/tur-lof Funeral, Jervice Licery ee	400	-	1300 E	Brothers I utaw Pla	ce Bal	al Service, P. timore, Md 2	21217		
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	the death. Do r		ar the mode of dyin		ardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner	er	Due to (or as a	consequence of	en	nic head		seus.	e		5 418	
o`	eath certificate be executed attending physician and for use as the burial-transit	Examiner		consequence of	of):	profre			ienha		1/	
9289	ficate be physicials the bu	edical	d	ene hic	, m	seulov c	Recia	lonh			11	
.O. Box 68760,	ο φ ο	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome part in the past 12 months? 4 □ Pregnant at the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in the past 12 months in	☑ Fetal death		Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year	
rds, P.	The law requires that the site has been signed by the page 2 should be detached.	<u>ک</u>	Part II. Other significant conditions contributing to death bu			derlying cause give	en in Part I.				to the cause of death? Probably 4 述unknown	
II Records,	sician: The law re certificate has bee irector, page 2 sho	Completed						_	24a. Was an autopsy pertormed	prior	autopsy findings available o completion of cause of ? es 2500	
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Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; r	ation: T	27. Manner of Death 1 DNatural 5 Pending (Month, Day 2 Accident investigation	Year) 28b. T	Time of njury	28c. Injun Work M 1 🗆		28	d. Describe how i			
DIVIS	Ital or Atters of trains after de rains Director led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injurbuilding, etc.					8	City or Town, S	tate)	Rural Route Number,	
	he Hosp in 24 hou he Funei pletely fili	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner stat	examination an								
	Voith To t	Σ	29b. Signature and title of certifier	nesh (	w	29c. License	3040	441		Date signed (Mo		
	3		30. Name and address of person who completed cause of de				"atons	rulle	mork	148		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	and a	10°						

Registrar

For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008° December Tully 9:00 Nellie Frances M A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6305 Furnace Branch Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 13, 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours 1919 Mary Land 219-01-3288 89 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multified at Director 1 ☐Yes 2 No Anne Arundel Glen Burnie Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ : any injury or other traumatic events. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21061 6305 Furnace Branch Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 🛣 No Specify: Specify: White <u>۾</u> 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Ewell Dorothy Sterling ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 Furnace Branch Road, Glen Burnie, Maryland 21061 Patricia J. Shelton (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12-23-08 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, Maryland 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In ediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequate of): /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the detached i 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 □ Yes 2 **N**No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Iniury 1 □Yes 2 □No 2 Accident investigation in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

law requires that the death certificate be executed P.O. Box 68760, Records. been has certificate Division of Vital this After Hospital or Attending death. 24 hours after deat Funeral Director: the the within To the 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Miller JOSEPH H MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miller mo

3495 WILKENS AUE \$203 Balling RE MD 21229 32, Registrar's Signature

and a

29c. License number

106982

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, 2. Date of Death **Physician** 1:10 PM ne Dec 6,2008 /Medical Name (if not institution, give street and number) or Location of Death 4c. County of Death 4b. City. Town. Examiner -ruination altimore are If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** 210-34-0760 1 □ M 2 🖫 F Months Days Hours Min 65 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. In Maryland Exemine must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Wes 2 □ No more 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO OT use retired) timore Elementary/Secondary (0-12) College (1-4or 5+) dth of Father's Name (First, Middle, Last) Be arren omai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mosher 2729 . Teterson 1 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 Removal from State 12.22.08 e of Funeral Service License e Funeral S Pike 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) Imale /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🥱 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes **EXINO** 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1∐ Yes 255K√lo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ANursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/Natural 5 ☐ Pending investigation 2 Accident 1 Yes within 24 hours after death To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Box 68760, P.O. Division of Vital Records, hours after death.

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

717 Hammands

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 29c, 30 per dvr g886, 12-22-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** A M Francis Anthony Veltre 2008 2442 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital at Easton

5. Social Security Number | 6. Sex | 7. Age (In yrs. last Talbot Easton 8. Date of Birth (Month, Day, Year Anril 30, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Year) 1**X** M 2□ F Months Days Hours Min 215-24-4658 80 Director 1928 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantime Lost Les multiped appre. Director 1 ☐ Yes 2 ☐ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 Seabreeze Road 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentist Own Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Veltre Carmella Bruno 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Veltre (Wife) 809 Seabreeze Rd., Cambridge, MD 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Other (Specify) Entombment Loudon Park Cemetery 12/20/08 Baltimore, Maryland 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acu te Qua disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The perform Division of Vital **≥**√100 1 ☐ Yes 2 HO 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐ Yes 2∑No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number **D-53110** 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219S. Washington St. Easton, Md. 21601 Dennis M. DeShields 31. Date filed (Month, Day, Year) 32. egistrar's Signature State South . Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 6:00 AM M Barbara Jean Vincent /Medical 2008 December 19, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8205 Arrowhead Rd. Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 X F Director 62 216-54-0727 09/21/1946 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Evancian in 11 to notified an Director 1 ∏Yes 2 X No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8205 Arrowhead Rd. 21208 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 USPS Elementary/Secondary (0.12) College (1-4or 5+) Postal Worker other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H I item 27 Is marked ott Be James H. Wilkins ပ Eleanor Mae Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine E. Witcher/Sister 1208 Eastover Pkwy Locust Grove, VA 22508 permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Dec 4 Donation 5 Dother (Specify) Beltsville, Maryland Chesapeake Crematory 2008 21. Signature of Funeral Service Licensee M01443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland
Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final colon **Physician** 2003-present disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) burial physician at the burial 68760 The law requires that the death certificate be Physician/Medical attending p as Box ( IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) signed by the a 0 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2**X** No s been si 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an as e 2 s autopsy performed? 1 🗆 Yes 2 💆 No page ? this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) dere Avenne Kumar 16VI 31. Date filed (Month, Day, 32 B State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19, 2008 1:55  $A^M$ Wolfe December James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 15, Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Hours Days Min. 1 XM 2 □ F Months 212-22-5963 82 Virginia Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Medical Examination and injury or other traumatic event, Item Medical Examination and injury or other traumatic event, Item Medical Examinations. **Funeral Director** N/A Baltimore 1 De Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 639 S. Lehigh Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland years Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Wolfe Thelma Wolfe ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Wolfe 639 S. Lehigh Street, Baltimore, Maryland 21224 wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2 Cremation 3 Removal from State 22, 2008 Rosedale, MD. 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Lice Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme liate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-trai P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No 2 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 versing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29a, Certifier 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 2 Marcel Place Dundale MD 21222 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Day 1921 M WARNER **Physician** STELLA 19 DECEMBER 2008 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 196-18-5602 84 1924 Director 13. Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f sho must be notified at 1 Yes 2 No Director Pennsylvania York York 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2520 Mt. Zion Road 17406 death v Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 😿 No Specify. Specify: þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 08 n/a Factory Assembler Office Furniture Mfg. 7 Is marked other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၀ Joseph Mvers Minnie Dubbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tratonce. Helen L. Myers 1926 Camp Betty Washington Rd., Red Lion, PA 17356 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/24/08 Zion Cemetery York, PA Service Licenses 22. Name and Address of Facility Bryan W. Clary Lemmon Funeral Home of Dulaney Valley 21093 10 W. Padonia Road, Timonium, MD the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications to at cause shock, or heart failure. List only one cause on each li Approximate Interval Between Onset and Death Immediate cause (Findisease or Inditional resulting in **Physician** DAYS TROKE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Kpg bunial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) signed by the at lid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b director, page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 XInpatient 1 🗌 Yes 2 ER/Outpatient 3 🗆 DOA မှ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural Injury 1 TYes 2 No death. eral Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier (check only Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of of rtifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Garde &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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DECEMBER 19 2008

600 North Wolfe St, Baltimore, MD, 21287

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Norman Williams		1- For State Registrar	Certif	ment of Health and Mental F iicate of Death	lygiene 2006 409 L
Physicia Medical Exami	-	1. Decedent's Name (First, Middle,Li	Williams		2. Date of Death Month Day Pear December 16, 2008  3. Time of Death 1952 hrs
		4a. Facility Name (if not institution, g Johns Hopkins Bayview	ive street and number)	4b. City, Town, or Location of Deat Baltimore	
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hr  Months Days Hours Mi	1=
Director		<b>Q15-16-9746</b> 1 Usual Residence of Decedent	LM 2 F 86	Yrs.	a·a·19aa country VA
w any	İ	10a. State 10b. County	10c. City, To	wn or Location	10d. Inside City Limits 1 Yes 2 100
aryland 8a-f sho	Director	10e. Street and Number	150	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f show notified at once.	i Dire	14 Barletta	a Court	21237	U.S. A
r death wit or items 2	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Wildowed 4 Divorce	1 Yes 2 No	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.) White, etc.
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be	17. Father's Name (First, Middle, La	e Jones	Sa	re (First, Middle, Maiden Surname)
MD 2 d 2 shoul tth and M n 27 is m	٥	19a. Informant's Name/Relationship	Villiams	14 Barle Ha Ct	Rural Route Number, City or Town, State, Zip Code)  Baltimore, MD 2 1237
Ore, es l an of Hea If iten	ĺ	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State 20b. Plac	ce of Disposition (Name of cemetery, natory or other place)	Date 20c. Location - City or Town, State
Baltimo permit. Pag Department Important: injury or o		4 Donation 5 Other Speci 21. Signature of Funeral Service Lice		22. Name and Address of Facility Co.	Mill of or car City of Controls
Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on		o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical xaminer		·	Multiple Injuries  Due to (or as a consequence of):		Death
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):		
ted 1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
ficate be executed g physician and sthe burial - transi	dical	UNPENDED	AMENDED		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be writin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar  1 Live birth  4 Pregnant at time of death	2 Fetal death 3 Ectopic pregr	23d. Date of delivery  Month Day Year
BO) he death the atth hed for	hysi	1 Yes 2 No 9 Unknow	9 Unknown		23e. Did tobacco use contribute to the cause of death?
P.O. es that the signed by be detacl	ρ	Fait ii. Other Significant conditions	contributing to death but not resu	Iting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certifi rs after death.  **I Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as t	Completed				24a. Was an autopsy findings available prior to completion of cause of death?
al Re an: The ertificate tor, pag	Be Co	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No conly one)
of Vitaing Physicial After this continueral directives	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ✓ EF		ing Home 5 Residence 6 Other:
on of ending lath.		27. Manner of Death  1 Natural 5 Pending	Dec 16, 2008 1	8b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury occurred Driver auto fixed object collision
Division of Vital P To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2  Accident Investigat 3  Suicide 6 Could not determin	ot be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc. Highway	28f. Location (Street and Number or Rural Route Number, City or Town, State) 6400 block of Pulaski Highway, Baltimore, MD
To the Hospita within 24 hours To the Funeral	Medical C	( Citating and	er On the basis of examination and/	death occurred at the time, date and place, an or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To with Con.	Me	29b. Signature and tile of certifier	and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)

OCME

Mary G. Ripple MD.

ess of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 17, 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 6:56 7M WILSON 01215 /Medical DEC 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ 🗶 Months Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational by mortified at Director 1 □ 2 2 □ No timore and Number 10g. Citizen of What Country? Funeral Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 📜 No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aughter Baltimore, 20a. Method of Disposition 1 ☐ urial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 20/2008 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) TYPOGLYCETUIA FILLEDIA ODATHY /Medical Due to (or as a consequence of) Examiner DAYS Sequentially list conditions, if any, each of the introduction cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PNEUMONIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy this certificate of Vital 1 □Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: Other: 1 inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 2008 DEC RESODU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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32 Registrar's Signature

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31. Date filed (Month, Day, Year)

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Ye ar 5 Mayfel 52 9:30 Y Ecember 17, 2008 /Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) 4c. County of Death NIA ntor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 € 72 Director Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show injury or other traumatic event, the Midical Examinar must be notified at Director 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 than "natural", or 1 ☐ Yes 2 ☑ No Specify. <u>۾</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygid Important: If Item 27 is marked other if any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ison Wilson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ughter 806 mont MOS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) rematery 23a. Palt1. Enter the mease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or feart before. List only one cause on each line.

Immediate Cause (Final disease or condition) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death **Physician** iveles disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CAVdi endo that the death certificate be executed by the attending physician and detached for use as the burial-trans weeks Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 Hospital or Attending Physician: The law requires venaldisease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☑ No Vital 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1120 ō Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 29c. License number cenber 15, 2008

State Registrar 31. Date filed (Month, Day, Year)

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N. Charles of Balto. Mil Zi Zox

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1641 Richard Carlisle Wright DECEMBER 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT AGNES HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 30,1940 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**XX**M 2□ F Yrs 68 Maryland 213-44-7657 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hedral Examiner must be notified at 1 Yes 2 No Director Baltimore Maryland n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3320 Benson Ave. 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: ģ 3XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 marketing retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked ofth any lininy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adele Carlisle Richard S. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 S. Calvert St. Suite 1400 Forrest F. Bramble Jr., Esq./P.R. Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Dec. 18,2008 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 pe of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BACTEREMIA DAYS /Medical Due to (or as a consequence of): **Examiner** DAYS MEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Apue The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ LNFARCTION 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown YAC 4RDIAL Completed DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an SENILE autopsy page. this certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sours

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DHMH 17 Rev 1/2001

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Begistrar's Signature

29c. License number

P20654

29d. Date signed (Month, Day, Year)

16 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year R. WALSCH WILLIAM 2008 10:30 PM 12 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 305 E. Joppa Rd. Towson Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 № M 2 🗆 F Yrs 80 Director 215-24-9508 11/30/1928 MD Usual Residence of Decedent death with the Maryland 10a, State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, Ins Modeal Examinating must be notified at Director MD 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Rd 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after , or 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify ੬ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1946-1947 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Motion Pictures Elementary/Secondary (0-12) College (1-4or 5+) Photographer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I Pages 1 and 2 should be William Richard Walsch Sr. Mary Allender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Peggy Walsch/Daughter 1900 Landrake Rd. Towson, MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 20 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2008 21. Signature of Funeral Service Licensee MO1443 22. Name and Address of Facility Cremation and Funeral Alternatives Kitter 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EMPHYSEMA disease or condition 10 YEARS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or imjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à GUILLAIN - BARRE SYNDROME has been signed to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 2 No 1 ☐ Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 12 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending s after dec. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00032186 ound May MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONRAD MAY MD, BALTIMORE VAME, ION. GREENEST., BALTIMORE MD 21201 31. Date filed (Month, Day, Year)
DEC 2 0 32. registrar's Signature State 2008 Registrar

/Medical Examiner The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-trai Division or Vital Records, P.O. Box 68760, the certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica After thi I Director;

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at place.

**Physician** 

Baltimore, Maryland 21215-0036

10a State Director 10e. Street and Number 25426 Private Lane Funeral 11. Marital Status 1 Never Married 2 Married Completed by 3 Widowed 4 Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Robert L. Anderson 19a. Informant's Name/Relationship (Type. Print) Kay B. Pinder 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Part1. Fiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or he of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No 2 27. Manner of Death Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a, Certifier (Check only one) and manner stated 29b. Signature and title of dertifie 29d. Date signed (Month, Day, Year) M 15108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy, M.D. 6602 Church Hill Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 2008

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		1. Decedent's Name (First, Middl	e, Last)					2. Date of D	eath		3. Time of Death
Physici /Medio		James	Frederi	ck		Armbrust	er, Sr.	Decemb	er L	y Year 1, 2008	7:20 P M
Examir		4a. Facility Name (If not institution	_			4b. City, Town,	or Location of Deat	h	40	. County of Dea	ith
		1015 Bedford				Cumb	erland	0.0-470			gany
Funeral Director	35	5. Social Security Number 212–38–6507		ge (In yrs. Ia: 68	st birthday) Yrs.	Months Days	Hours Min.	(Month, D	ay, Year,	)   C	thplace (State or Foreign ountry)
		Usual Residence of Decedent						01/14	/ 194	0 Mar	yland
yland how at		10a. State 10b. County		10c. City,	Town or Lo	cation				_	10d. Inside City Limits
e Ma Ba-fs tified	cto	MD Alle	egany		Cum	berland					1 X Yes 2 □ No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	ountry?
sath v s 23a nust	eral	1015 Bedfor		From in II C	140.1	Vac Daggerent of I	21502			14. Race - Ame	USA
iter de item iner r	Funeral	11. Marital Status 1 □ Never Married 2 🛣 Mari	12. Was Decedent Armed Forces?	)	.   13. Y	Yas Decedent of I	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	0-	Black, Whi	
urs af al", or xami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1962	2 1	☐Yes 2☐No	Specify:			Specify:	White
72 ho	Completed	15. Deceden	it's Education est grade completed)		16a. Deced	ent's Usual Occu	pation during most of wo	rkina	16b. K	(ind of Business	/Industry
ithin nan "i	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retire	d)	ming			
fygier her th		12 17. Father's Name ( <i>First, Middle,</i>	( ont)		Ma	intenand	18. Mother's Nar	no /First Middl			ling Group
intal H ed of ed of	Be	Frederick	William	Arr	nbrust	er	Rita	Ma		· · ·	ill
should od Me mark matic	2	19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Number or Ri		- 7		
nd 2 state at trau		Rose Marie Ari	nbruster / W	ife			Street,				1502
S 1 a of Height		20a. Method of Disposition	- 5-	rei	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
Page nent d int: If		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (S			Vet Ce	em @ Rock	cv Gan 12	/9/2008	Fl	intston	e. MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: I fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Ligensee		22	. Name and Addre	ess of Facility Ad	ams Fam	ily	Funeral	Home, P.A.
20 E 20		Heller	udams				ur Stree			nd, MD	21502
		23a. Parth. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each in	d the death. ine.	Do not ente	er the mode of dyi	ng, such as cardia	,			Approximate Interval Between Opeet and Death
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. 1/1 eth.	STATIO	e K	enal	all	Can	er		6 mos
Examiner			Due to (or as	a conseque	ence of):						
4	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of):						
executed in and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	<b>6</b> c.								
e exe ian ar urial-t		resulting in death) Last	Due to (or as	a conseque	ence of):						
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medica		d								
ding p	/Me	IF FEMALE:	23c. If yes, outcome	onf pregnan	CV						
Ine law requires that the death certificate be the has been signed by the attending physicial age 2 should be detached for use as the bur	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal o	death 3	Ectopic pregnand Other (specify)_	у			23d. Date of de Month	livery Day Year
the d ty the ached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			(4,000)/ =					
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as be 2 sho	Completed							24a. Wa	s an	24b. Were a	utopsy findings available completion of cause of
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fr. : Afte : fune	tion	1 Natural 5 Pendir 2 Accident investi	ng (Month, Da	ıy Year)	Injury	Wo	rk?  Yes 2 □ No	Zod. Dodolibo	now inju	ry occurred	
Atter	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined   28e. Place of Inj	jury - At hom tc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location	(Street a	nd Number or R	ural Route Number,
s afte al Dir ed in	Certification:	4 Intomicide	building, et	ic. (Specify)				City or To	own, Stati	e <i>)</i>	
To the hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 \(\infty\) Certifyir (Check only one) 2 \(\infty\) Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at the trestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(s e, date an	s) and manner a d place, and du	s stated. e to the cause(s)
vithin To the	Me	29b. Signature and title of certifie	f 1			29c. Licens	se number		29d. Da	ite signed (Moni	th, Day, Year)
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		30. Name and address of person	//			,					
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Sta Registr	_	31. Date filed (Month, Day, Year)	0 5 2008 P	ar's Signatu	K.	Sparte					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1359 2008 Emily Aaron Mary 2 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Dorche Ster General Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** Year) 1 ☐ M 202 F Months Days Hours 215-26-5567 78 Director Apr 20, 1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 100 Hayward Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2★ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 XNo Specify: à white 3℃ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Elizabeth Williamson John Francis Trice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3630 Karen Circle, Linkwood, MD Nancy L. Roberts daughter 21835 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/15/08 Maryland Veterans Cem! 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. len 700 Locust Street, Cambridge, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏ Yes 2 🖭 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

attending physician ğ the signed by t I be detach peen has page 2 Hospital or Attending Physician: The certificate director, this funeral After death. nours after death.
neral Director; A
filled in by the fu 24 hours a completely To the within 2.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evantinar must be notified at

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permit. Pages 1 and 2 should be filed wir Department of Health, and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event

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Baltimore, Maryland 21215-0036

3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29b. Signature and title of certification

29a. Certifier

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Moi

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 11 2008 CHARLES S. BOOZ, 7:35 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b.-City, Town, or Location of Death 4c. County of Death Examiner Chestertown Kent Heron Point - Talbot Wing | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 21. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 2 M 2 □ F Feb 1925 354-16-3908 83 Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show Examiner must be notified Kent Chestertown 1X Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 120 Heron Point 21620 23a U.S.A. Funeral items ; 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married ,0 1 ☐ Yes 2 🕱 No White þ Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Chemical Company Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles S. Booz, Genevieve Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) Michael S. Booz 827 Hollyridge Dr. Encinitas, CA. 92024 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/12/08 Kent Cremation 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 21. Signatura | Funeral Service License 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, M00510 21635 23a. Part1. Enter the disease, or complication, that caused the death. Do not en shock, or head failure. List only one can be one and line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Ca (Final disease or condition resulting in death) 66 Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes autopsy performe Yes 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours aft

To the Funeral Di

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Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

I Director;

Medical and mapper stated. 29b. Signatu nd title of certifie 29c License number 29d. Date signed (Month, Day, Year) 10060301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1 M.D. 122 Speer Rd. Chestertown, MD. Michael Peimer

State Registrar

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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				21			DO	05400	4			ember 2		
	3		30. Name and address of person who	completed cause of dea	1110 (Item 23a) (	Type Prin	nt)				-			
	NRS		Shiv C. Khanr	na, M.D.,	1221 Na	ation	al High	way,	LaVal	e, MD	21	502		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 2 2008	32. Registrar	s Signature	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Gino Bernacchia 29, November 2008 8:05 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3158 Drawfield Lane Huntingtown Calvert County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 M 2 □ F Months Days Hours Min. 013-18-8338 19, 1918 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Calvert County <u> Huntingtown</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3158 Drawfield Lane 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Federal Protection Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albano Bernacchia Annunziata Falchoni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Mohn (Daughter) 3158 Drawfield Lane, Huntingtown, Maryland 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2008 Clinton, Maryland 21. Signature of The Tolking to the page 22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show inver must be notified at

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r than "natural", o

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than 'any Injury or other traumatic event, it alway on other traumatic event, it alway once.

Director

Funeral

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Completed

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MD

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

burial-trar physician attending plant of for use as ned by the been si page 2

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

SUL

Dhiren H. Shaw, M.D.

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital or Attending

	Michael W. La	e 8	3125	Southern Mary	land Blvd	l., Owings,	MD 20736
	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition			mode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Each underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Jr.	whifile			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			pic pregnancy r (specify)		23d. Date of del Month	ivery Day Year
Completed by P	Part II. Other significant conditions col	ntributing to death but not resulting in the	underlyi	ng cause given in Part I.		oacco use contribute to	o the cause of death?
	05 W				24a. Was ai autops perforn 1 □ Yes 2	y prior to o	topsy findings available completion of cause of
e n	25. Was case referred to medical examiner?	Hospital:			ath (Check only on		
2	TE TES ZEDAO	1 Inpatient 2 ER/Outpat		DOA Other: 4 Nursing H	Home 5X Reside	nce 6 ☐ Other (Spec	cify)
eruncation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, fa	ctory, office	28f. Location (St. City or Town	reet and Number or Ru , State)	iral Route Number,
ealcal	29a. Certifier 11 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occu investiga	rred at the time, date and plac ation, in my opinion, death occi	e, and due to the courred at the time, do	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
Ξ	29b. Signature and title of certifier			29c. License number	25	d. Date signed (Month	n, Day, Year)

D 50250

110 Hospital Road, Suite 303, Prince Frederick, MD 20678

December 1, 2008

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf g886 12-30-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician James F. Bradley 28 2008 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Onder 1 Year | If Under 14 Hrs. | 8. Date of 10 8. Date of Birth (Month Day, May 13, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Year 947 **IX**M 2□ F 61 Washington, DC 578-66-7976 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If weller I is it in it is it in it it is an infilled at Anne Arundel Annapolis 1⊈Yes 2□No Funeral Director Maryland 10g, Citizen of What Country? 10e Street and Number 10f. Zin Code 21403 1812 Glade Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2★2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2**XX**No Maryland 21215-0036 1 ☐ Yes 2 💽 No Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Software Engineer Computers 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James F. Bradley Madeline Benton 2 19a. Informant's Name/Relationship (Type. Print)

Muhammad Jami nephew
Ingrid Henderson/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1126 South Thomas St. #22 Arlington, VA 22204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Bethel Cemetery 12/3/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) povolemi **Physician** /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Venous Shurt. Hospital or Attending Physician: The law requires that the death certificate be exect Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by completely filled in by the funeral director, page 2 should be 1 🗌 Yes 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 To the Deputy 29c. License number 29b. Signature and title of certifier

Con .

State Registrar 31. Date filed (Month, Day,

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

DEC 0

ones

32. Registrar's Signature

			1 - State of Mary	rland / Department of Health and N Certificate of Death		ene 2 0 0 8	10953
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		James Baren		Month 1.7	Day Year 2008	0100 M
	/Medio Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	0,00
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	Funeral		The Marie	n yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthn	place (State or Foreign
	Director		333-32-7032 1₽M 2□F	76 Yrs. Months Days Hours Min.	(Month, Day, )	1932 Illi	ntry)
			Usual Residence of Decedent	19	W.C. 3,	1732 1111	11013
	land			Oc. City, Town or Location		1	Od. Inside City Limits
	Mary f sh	5	Maryland Anne Arundel	Annapol:	is		Yes 2 □ No
	the ?	ect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	
	the state	급	1933 Fairfax Road	21401	100	U.S.A	*
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-1 show than "neturel", or Items 23a or 28a-1 show the Mulical Exer. in or must be notified at	by Funeral Director					
	er de	nue	11. Marital Status 12. Was Decedent Eve Amed Forces?	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	o afte	γF	1 ☐ Never Married 2 ☐ Married 1 ☐ No If Yes, Give	1952–55 1 Yes 2 <b>XD</b> No Specify:		Specify:	White
Ö	Jonus	d b	3 Widowed 4 Divorced Year or Dates:			0,000,000	7,112.00
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2	be filled that tall Hydronthe event	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Sumame)	
<u>a</u>	Aent Aent rkec tic e	2	Richard O. Bacon	Etnel	F. Smith		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importents if item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Mudical Exactiment must be notified as once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, (	City or Town, State, Zip	Code)
	and 2 salth a n 27 is		Evelyn Bacon/wife	1933 Fairfax Road Ani	napolis,	Maryland 2	21401
ē,	Hez Hez tem othe	- 1	20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20	Oc. Location - City or To	wn, State
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불	rten rten njur		* 4 □Donation 5 □Other (Specify)  21. Signature of Euroγal Service Licensee				
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of Vital	Physicien: this certificaral director, I	Be	25. Was case referred to medical examiner?		h (Check only one)		
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	ng F fter mera	ü	27. Manner of Ceath 28a. Date of Injury 1 StNatural 5 ☐ Pending (Month, Day Ye	28b. Time of 28c. Injury at Work?	28d. Describe how	injury occurred	
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Division	for Attendater deatl Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury-building, etc. (5	At home, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural	Route Number,
	s after al Direct ad in by	Certification:	50.00.00	,	ony or 101111, c	Jidio)	
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	De Hi De Fu De Fu	Medical	(Check only 2 Medical Examiner: On the basis of examiner)  and manner stated.	amination and/or investigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)
	omp	M	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, L	Day, Year)
		7	Dans 10 000	100 DUETA		12/3/10	
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1	S'BY		30. Name and address of person who completed cause of death	2001 Med tel Kerkury	1	D: 1. 1	2/6/21
	- Pr		31. Date filed (Month, Day, Year) 32. Registrar's		map	us m/)	1401
	Sta	-	31. Date filed (Month, Day, Year) 32; Registrar's DEC 0 5 2008	Digitatule A	,		
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5	Physicia		1. Decedent's Name (First, Middle, Last)  Edna Louise Cavey	ī					2. Date of Dea Month ovembe:		2008	3. Time of Death 11:25 PM
	/Medic Examin	_	4a. Facility Name (If not institution, give street and numb			4b. City, Town, or	Location of				ty of Death	
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ų.	Funeral Director		578-18-1948 1□M 2\F	Age (In yrs. last birth		If Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day arch 9,	, Year)	Coul	place (State or Foreign ntry) n Carolina
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	with 3a or t be r	ă	821 Cove Point Road			20657				United		,
	er death Items 2; ner mus	Funeral	11. Marital Status	es?	13. W	as Decedent of His Yes, specify Cuba	spanic Origi n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Ra	ce - Americ ack, White,	can Indian,
3-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3 X Widowed 4 Divorced If Yes, Give Year or Date	es:		☐ Yes 2 No	Specify:			Speci		ite
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VISIOII OF	nding Pi th. ': After ti e funera		27. Manner of Death  127. Matural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of (Month,	Injury 28b. Tir Day Year) Inj	me of jury	28c. Injury Work M 1 1	/at t? Yes 2 ∐ N		d. Describe h	ow injury occu	irred	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	f injury - At home, farn I, etc. <i>(Specify)</i>	n, stre	et, factory, office		28	f. Location (S City or Tow		ber or Rur	al Route Number,
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	To th within To th comp	Me	29b. Signature and title of certifier	110		29c. License				29d. Date sign		
)	_		I Wand & I wels	0 7/			7610		1	Occum l	00	1, 2008
Į.	2KM		30. Name and address of person who completed cause	of death (Item 23a) (T Hospital Ro			Drin	o Ev	bride 1	VD 20€79		
	Sta	te	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	acilly	SOTTON 210'	FLIID	e trec	ETICK, I	-10 ZU070		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month 12:00 PM December 2008 Gladys Alverta /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/22/1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 F Washington, 579-12-2722 88 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23e or 28e-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director MD Harwood Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20776 Solomons Island Road 4187 death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or lier any injury or other traumatic event, the Modical Examinat once. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 banking assistant manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Warden Carrie Alverta Carrick Herman George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Lou Donn McConkey, daughter 11771 Adrian Lane, LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 X Removal from State
4 □ Donation 5 X Other (Specifient om bment Brevard Memorial Park 12/10/2008 Cocoa, Florida Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the use se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (First disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner infection Due to (or as a considence of): trant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed end Stege
Due to (or as a consequence of): Alzheimer that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Munknown 1-14 per tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dichetes autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Coronar Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the t 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/03/2008 1805000 had? parac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parke 1-10000112 31. Date filed (Month, Day, Year) 32. Registres Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Menital Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year OS Month **Physician** ames aUIS 1510 12 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** m AAMC Avunda ANNAPOLIS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F Days Hours 215-80-2390 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD Glen Burnie ral", or items 23a or 28a-f sh Examiner must be notifled Anne Arundel 1 ∐XYes 2 ∐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Water Fountain Way Unit 102 21060 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**√**□XNo þ Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Manager Giant Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Evans Davis Mary E. Wood ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27580 Burrsville Road, Denton, MD 21629 Harry E. Davis/Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bloomery Cemetery 20a. Method of Disposition 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State 12/10/08 Smithville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran and Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 Natural 1 🗌 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature a

(Check only one)

Armee

31. Date filed (Month, Day,

DEC

Medical

State

and manner stated.

Ame

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2008

Tycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Medical

29d. Date signed

			For State	State of Maryland	/ Depa	artment	of He	alth an	•		•	1.0050
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08-09337	
William H. D	egrange

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Hospi 24 hou Finite tely fi	C	29a. Certifier 1 Certifying Physician: To the best of m	ny knowledge,	death occur	red at the tin	ne, date	and place	e, and di	ue to the ca	use(s) an	d manner	as stated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Finieral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	one) 2 Medical Examiner:On the basis of exa and manner stated	mination and/	or investigat				urred at t	he time, da				
	ž	29b. Signature and title of certifier				icense r							, Day, Year) o
		hy w. m.s		-		).C.M.	.c.			Dec	ember	13, 200	
1		30. Name and address of person who completed cause of Ling Li, MD Assistant Medical Examine			et, Baltimo	re. M	D 2120	)1					
_ '	a la	9 1	ar's Signature		ot, Bartinia	.,							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) PM Month Year 1634 **Physician** a g November Robert Dickerson 2008 John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Dorchester General Hospita ambadge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 10, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1934 Months 1 XM 2 □ F Days Hours Maryland Aug. 74 Director 214-30-9223 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State death with the Marylan ns 23a or 28a-f shormust be notified at Cambridge 1 □Yes 2 □No MD Dorchester Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 USA 10 Harris Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 11. Marital Status ? Is marked other than "natural", or iten traumatic event, the Medical Examinar Black, White, etc. 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1954–58 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white ≥ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction bricklaver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ဂ John Turner Dickerson Evelyn Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 67060 8815 South Hydraulic, Haysville, KS Clement T. Dickerson brother item 27 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 5 permit. Pages
Department of
Important: If it
any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 12/5/08 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Nk I tem 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 25 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner?
1N Yes 2 □ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

24 hours a

Dickerson

within 2 To the I

State Registrar

29c. License number 0-31730

29d. Date signed (Month, Day, Year)

ise of death (Item 23a) (Type, Print)
CF MD 300 BYRN ST. CAMBRIDGE, MD 21613

**DEC 04** 2008

and manner stated

			1 - For State Registrar	State of Maryland /	-	rtment of H rificate of L		and M		iene 2	008	40961	
			1. Decedent's Name (First, Middle, Last)			······································			2. Date of Deat Month	th Day	Voer	3. Time of Death	
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	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or		f Death		/	nty of Death		
81			5. Social Security Number 6. Sex	7. Age (In yrs. last bi	ieth day)	If Under 1 Year	If Under 2	24 Hrs. T	8. Date of Birth		100M10	Olace (State or Foreign	
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at yiaild 21213-0030 should be filed within 72 hours after death with the Mandand	al Hy d othe	Be (	17. Father's Name (First, Middle, Last)						(First, Middle, I	Maiden Surn	ame)	***	
ylan ylan	Ment Ment arked artic e	10	HERBERT JOHNSON						BARTLEY				
Mar	h and 7 is n traun	(i) }	19a. Informant's Name/Relationship (Type	1		Address (Street a					vn, State, Zip	Code)	
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allillior	perim. Fages I and Should be fled within 72 flours after beath with the way yat boppartment of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State ST. GE	ery, cřema CORGE	tory`or other place S CEMET	ERY 1	2-10	-08	FRANKI	FORD,	DELAWARE	
	Departm Departm Importal any Inju		21. Signature of Funeral Service Licensee	2 /	MH.	Name and Address LSON_FUN	ss, of Facility	SERV	TCES LT	D			
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	hysician		Immediate Cause (Final disease or condition resulting in death)	UTRRIN	R	CAR	CIA	10 cm	A			Onset and Death	
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Jan the	de atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ ¶o	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		Ectopic pregnancy Other <i>(specify)</i>	У				Month	Day Year	
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Attending	eath. Ior: A the fu	catic	2 □ Accident investigation				Yes 2 □ N	No					
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lospita	within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying Physic	ian: To the best of my knowledger: On the basis of examination a	je, death	occurred at the tinestigation, in my o	ne, date an	d place, a	and due to the o	ause(s) and	manner as s	stated.	
the F	thin 2.	Medical	29b. Signature and title of certifier	and manner stated.		29c. License					ned (Month,		
٩	₹ ¥ ₽ 8	_	200. Olginature and tibe of certifier	3				41.	1			-	
			30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, P	rint)	0	1,,,		1	1/100	suprisor	
BI	A 8			COASTAL HOS		e P.U	DOP	173	33 SA	uj Bl	wy	morisor	
		to	31. Date filed (Month, Day, Year)	32 Registrar's Signature							1		

Registrar

DEC 0 9 2008 Some & Speck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Norris Alford English 3008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WI COM COASTAL DALISBUR HOSPICE AT THE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 3,1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 XM 2 ☐ F 215-26-4921 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Wedien Evantimer must be reutified at 1 ☐ Yes 2 No Director Maryland Wicomico Delmar 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21875 30294 Mallard Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 195 14. Race - American Indian, 11. Marital Status Black, White, etc. 1954-1 Never Married 2 Married 5-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1956 Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 hc th and Mental Hygiene. 7 is marked other than "natul 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Truck Transport Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Nellie Valliant Messick Oscar James English ပ and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health an Important; If item 27 is any Injury or other trau 30294 Mallard Drive, Delmar, Maryland 21875 Nancy English/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 Removal from State MD Veterans Cemetery 12/10/2008 |Beulah, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Sign ture of Fineral Service Ligense 23d. Parvl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RRCTO SIGMOID CARCINONA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MELANOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ACCIDENT that the death certificate be executed burial-transit CERRBROVASCULAL and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 □Yes 2 TNo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) HOSPICA 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058410 12/6/08

Registrar DHMH 17 Rev 1/2001

State

COASTAL HOSPICA strar's Signature

P. U BOX 1733 Spain Bruy and 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Re

6 HUGH WAMY

31. Date filed (Month

Year)

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			For State	State	of Ma	ryland / [		artmeni <i>tificate</i>				, ,		000	0 3		100
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	Physicia		Lula Beal Early						Dec					Ž, 2008	5 6	:31	Ам
	/Medic Examin		4a. Facility Name (If not institution	·	number)			4b. City,	Town, or	Location of				c. County of De	ath		
Í		•	Peninsula Regional	Medical Ce	nter			S	alis	sbury				Wicomi	СО		
1	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ VF	7. Age	(In yrs. last bii	rthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Birth $Month, Day$	h /, <i>Year</i>	9. E	Birthplace Country) nness	(State or	Foreign
e.	Director		578-36-8006 Usual Residence of Decedent	XX	93		TIS.				I.	nay 21,	19	713 Te	mess	see	
	land ow		10a. State 10b. County		T	10c. City, Tow	n or Lo	cation							10d. Ir	nside City	y Limits
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	th wit	alD	2845 Crocheron	Road				2	1627				Uni	ted St	ates		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygene. If Health and Mental Hygene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status		Forces?		13.	Was Deced If Yes, spec	ent of Hi	isp <i>a</i> nic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ar Black, W		di <i>a</i> n,	
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7	d with giene ar tha	)om	Elementary/Secondary (0°12)	1		, <u> </u>	H	ospit	alit	у			Fo	ood Ser	vice		
2	al Hy l othe	Be C	17. Father's Name (First, Middle,									(First, Middle,	Maide	n Surname)			
2	Ment Ment arked aric e	Tol	Stephen Davenpo	rt ————						Allie	e Ower	ns ———					
3	2 sho		19a. Informant's Name/Relations					_					-	or Town, State			
5	land Health Im 27 Ther to		Ruby N. Younker	/ Daugn	ter			Croch			Da			larylan ocation - City			
5	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee.		20a. Method of Disposition  XXX Burial 2 ☐ Cremation		m State	20b. Place of cemeter Hillcres								apolis			nd.
5	it. Partmen		4 ☐ Donation 5 ☐ Other (S 21. Signature of Fungral Service	4		пппсе								or Fune		-	
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2	res th igned be de	by f	Part II. Other significant conditi	ons contributing to	death but	not resulting i	n the u	nderlying ca	ause give	en in P <i>ar</i> t I				use contribute to the cause of death?			
2	w requir been si should	ted										1 0 1	res 2	Z <b>K</b> NO 3	Probably	4 🗆 0	nknown
ט	has b	Completed										24a. Was a	sy	24b. Were	o complet	indings a tion of ca	available ause of
5	Attending Physician: The sr death. rector: After this certificate haby the funeral director, page											1□ Yes	rmed? 2 XN	death 1 ☐ Y		No	
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:					Othe	or:		(Check only o					
5	ing Phys I. After this funeral di	: To	1 ☐ Yes ZXNo  27. Manner of Death	11	☐ Inpatien te of Injury		Time o	nt 3□ D0 f 2	8c. Injur Worl	4 L N		e 5∐Resid Bd. Describe h		6 □Other (S	pecify)		
To the Hospital or Attending Physician:	ding th. : Afte e fune	tion	1XXIatural 5 ☐ Pendir 2 ☐ Accident investi	19	onth, Day	Year)	Injury	М		ƙ? Yes 2 □			,				
	Atter	ifica	3 Suicide 6 Could	nined   Zot. Fiz			arm, str	eet, factory	, factory, office 28f. Local				ation (Street and Number or Rural Route Number,				ber,
5	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)														
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (		ng Physicien: To Examiner: On the		examination a											)
	ithin ithe	Med	29b. Signature and title of certifie	-//-,	anner stat	eu.		290	. License	e number			29d. D.	ate signed (Mo	nth, Day,	Year)	
	⊢ ≯ <b>⊢</b> ŏ	1	> Made	HALL.					D	29349	9			Decembe	er 3,	200	80
	than,	)	30. Name and address of person				(Type,	Print)									
	1/20		Dr. William F	Jami 1ton	Robbi	nc 20	0 0	izzio	Aven	ue S	Salisk	oury, M	D	21804			
	Sta		31. Date filed (Month, Day, Year)	) = 2000	. Registra	r's Signature	4										
	Registr		DEC	0 5 2008	1386	was L	*	GOOM.									
JHI	MH 17 Rev 1/2	UU1					4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $15^{\text{Day}}$ 1<sup>Month</sup> 2008ar FELKER 0845 CHARLES 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death WMHS MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Country) . 1928 Months Days Hours 1 → M 2 □ F Feb 20, Yrs. 212-24-1105 80 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ¥Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 15 East Elder Street 21502 USA Was Decedent Ever in U.S. Armed Forces? 1 May 2 No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ N Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) boilmaker/welder B&O & CSX Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felker Frank Felker Grace 19a. Informant's Name/Relationship (Type. Print)

Jacqueline Felker 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 East Elder Street MD 21502 wife Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/17/2008 MD Cresaptown 4 ☐ Donation S ☐ Other (Specify) 21. Signa ure of Funk ral Service Ucensee 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e cause on each line. . Part 1. Enter the disease shock, or heart failure. e or complication of the last only one Approximate Interval Between Onset and Death HOURS ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): YEARS CHRONIC ISCHEMIC HEART DISEASE Due to (or as a consequence of): Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Insportment of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Madical Exp. it is fraugable to other traumatic event, it is Madical Exp. it is fraugable.

Baltimore, Maryland 21215-0036

physician and the burial-transit attending p for use as t signed by the a certificate has treector, page 2 s funeral s after death.

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Immediate Juse (Final disease or ndition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 SEVERE AORTIC STENOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE autopsy performe 1 ☐ Yes 2 DIABETES MELLITUS Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 28a. Date of Injury 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury (Month, Day, Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

10

within 24 hours a

To the Funeral C

completely filled filled

To the Hospital

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

2 No

D0062929

**DECEMBER 15, 2008** 

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 MEMORIAL AVE., CUMBERLAND, MD

EMMANNEL OSEI-BOAMAH,

31. Date filed (Month, Day, Year)

2008



08-09139 Henrietta Fagan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

, motta ragan		- For State Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Certification - Ce	ificate of Dea	ath	Reg.	No.		
Physicia	ın/	Decedent's Name (First, Middle,Last)			2. Date of Death	av Year	3. Time of Death	
edical Exami		Henrietta Lucille	Fag		December 5	, 2008	0854 hrs	
		4a. Facility Name (if not institution, give street and number) Western Maryland Health Systems	1 1	r, Town, or Location of Deat mberland		4c. County of Death Allegany		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las		nder 1 Year   If Under 24Hi nths   Days   Hours   Mi	_	MM/DD/YYYY) 9. Bir Foreig 940 Co	thplace (State or In Maryland untry)	
hours after death with the Maryland 'natural'', or items 23a or 28a-f show any Examiner must be notified at once.	Director	MD Allegany  10e. Street and Number 14102 Kizzie Lane, NE  11. Marital Status 12. Was Decedent Ever in U.S	10f.	erland Zip Code 21502 edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No-	. Citizen of What Cou USA 14. Race - Amer White, etc.		
5-0036 led within 72 hours after death Hygiene. other than "natural", or iter the Medical Examiner must	Completed by Funeral	Elementary/Secondary (0-12) College (1-4 or 5+)	1 Yes  16a. Decedent's Usiduring most of	2 <sup>X</sup> No specify: ual Occupation (Give kind o working life. DO NOT use re President	work done	Specify: Will 6b. Kind of Business/	•	
21215-0036 Juld be filed within 7 I Mental Hygiene. is marked other than ic event, the Medica	Be	17. Father's Name (First, Middle, Last)  Carl Beck  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Addr	18.Mother's Nan Louise ess (Street and Number o		nabelle	Burnworth e, Zip Code)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Heath and Neural Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.		Edward L. Fagan / Husband  20a. Method of Disposition  1   Y   Burial   2   Cremation   3   Removal from State   or	14102 K Place of Disposition (incrematory or other place) Vet Cem 6 22. Name a	izzie Lane,	NE, Cumbe Date 2/09/2003 ams Famil	erland, MD 20c. Location - City of Flintsto y Funeral	21502 Town, State One, MD Home, P.A.	
Physician M i l Examiner	Examiner	23a-Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	r): r):	de of dying, such as cardiad	or respiratory arres	it, shock, or heart	Approximate Interv Between Onset an Death	
760, icate be executed physician and the burial - transit	Medical	events resulting in death) Last  d.  UNPENDED  AMENDED  IF FEMALE:  23c. If yes, outcome of pregn				23d. Date of delive		
the death certific by the attending I ched for use as th	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not re	J Other (	Specify)		Month  acco use contribute to	Day Year of the cause of death?	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi	Completed by				1 Yes  24a. Was a autops perforr 1 Yes 2	n 24b. Were a y prior to ned? death?		
tal F cian: Certific ector, p	Be C	25. Was case referred to medical examiner?	ED/O	26.Place of Death (Che		Residence 6 Oth	or.	
ion of Virtual physicath or: After this the funeral dir	ation: To	1 V Yes 2 No 1 Inpatient 2 V  27. Manner of Death 1 Natural 5 Pending 2 V Accident Investigation	ER/Outpatient 3 28b. Time of Injury 1800 hrs	28c. Injury at Work?  1 Yes 2 ✓ No		ow injury occurred		
Division  To the Hospital or Attend within 24 hours after death  U. To the Funeral Director: completely filled in by the:	Certification:	3 Suicide 6 Could not be 4 Homicide Could not be determined (Specify) Single Fam	ate) ane NE, Cumberla	d Number or Rural Route Number, Cit E, Cumberland, MD				
To the Hos vithin 24 h To the Fun ompletely	Medical	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred a and/or investigation, i	n my opinion, death occurre	nd due to the cause d at the time, date a	and place, and due to	the cause(s)	
5	Ž	29b. Signature and title of certifier  Mlun Brasse W. MV		O.C.M.E.		December 6, 20		
ndo		Name and address of person who completed cause of death (Item     Melissa Brassell, MD	ner 111 Penr	Street, Baltimore, M	D 21201			
Regi	tate strar		Land.	,				
DHMH 17 Rev 1	2001		ORIGINAL					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 8, **Physician** 2008 3:15 P M Robin Lynn Finlay /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1959 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Washington, D.C 1 □ M 2 🗓 F Months Days Hours Min. 212-82-6249 49 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be nuttiled at once. 1 ☐ Yes 2 No Director MD Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 USA 4413 Morningwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2\( \text{M} \) No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Consultant Information Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Don Andrew Waite Marian Anderson ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 Morningwood Drive Olney, MD 20832 David Finlay/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arundel Crematory | 12/09/08 4 □ Donation 5 □ Other (Specify) Odenton, MD Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licenses MO1251 Beverly I. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Permeral Director: After this certificate has been signed by the attending physician and letely filled in by the theral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 □Yes XXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) hospice Hospital: Certification: To 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🕍 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koucetchou, mo Jocely ne 200 63 748 December 9, 2008 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 0 9 2008

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

08-09136 Jerome Fox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2008 40967

		Registrar Certificate o	t Death	Re	g. No.		
Physician/ ledical Examine		3023110 112020 1311	2. Date of Death Month December	Day Year 5, 2008	0325 NFS		
	ı	4a. Facility Name (if not institution, give street and number)  Easton Memorial Hospital	4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  135-70-2123 1XM 2F 31 Yr	If Under 1 Year If Under 24Hrs Months Days Hours Min			Birthplace (State or Foreign Country)  NJ	
	ŀ	Usual Residence of Decedent		[ 07/20/	71777		
nd show any ice.	١	10a. State	tion			10d. Inside City Limits  1 Yes 2 X No	
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?	
th the Maryland 23a or 28a-f sho notified at once		6907 Quail Run	21643		U.S.A.		
t be n	Funeral		as Decedent of Hispanic Origin? ( Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-fahr tranmatic event, the Medical Examiner must be notified at once	by Fur	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	,		hite	
hours		15. Decedent's Education (Specify only highest grade completed)  16a. Decede during n	nt's Usual Occupation (Give kind of v nost of working life. DO NOT use reti		16b. Kind of Busines	s/Industry	
1215-0036 Id be filed within 72 hours after fental Hygiene narked other than "natural", event, the Medical Examiner	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	1.1 - 3		/ .		
5-0036 led within 7 Hygiene. other than	<u>ا</u> ق	12 Disa	18.Mother's Name	e (First, Middle, M	N/A Maiden Surname)		
21215 vuld be file Mental H marked o	Be (	Gray A. Fox	Kathlee	n Marie	Deren		
21 hould nd Me is man			ng Address (Street and Number or I			ate, Zip Code)	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other transmatic event, the Med	-		Quail Run, Hurl	ock, MD	21643 20c. Location - City	or Town Chats	
nore, ages la nt of He nt: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or o	ther place)		ĺ		
t. Pag t. Pag tment rtant:	-	4 Donation 5 Other Specify:		9/2008	Greensbo	ro, MD	
Baltimore, permit. Pages I am Department of Heal Department of Heal Important: If item injury or other tra		F1	Name and Address of Facility .eegle and Helfen	bein Fur	neral Home		
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	16 W. Sunset Ave. the mode of dying, such as cardiac o	Greens or respiratory arre	shoro, MD est, shock, or heart	21639 Approximate Interval	
/Medical	ı	failure. List only one cause on each line.  Immediate Cause (Final disease a Postsurgical Hemorrhage following	g Dialysis Graft Placement			Between Onset and Death	
kaminer		or condition resulting in death)  Due to (or as a consequence of):					
"Married Par	ا ي	Sequentially list conditions, if any, leading to immediate  b. Anticoagulation Therapy for Meching to immediate  Due to (or as a consequence of):	anical Heart Valve				
		cause. Enter Underlying Cause (Disease or injury that initiated					
scuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.					
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18760, tificate by mig physic as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Females	etal death 3 Ectopic pregna	ancy	23d. Date of delive Month	ery Day Year	
O. Box 6 at the death cert by the attenditated for use a	Sicia	Pregnant at time of death 5 0	ther (Specify)				
the dex	Physicia	Part II. Other significant conditions contributing to death but not resulting in the	underlying course given in Part I	23e Did to	hacco use contribute	to the cause of death?	
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rds, require peen sign phould be	Completed			24a. Was a	n   24b. Were	autopsy findings available	
cor e law r e has b	ğ E			autops perfor	med? death?		
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 V Yes 2	2_No 1 🗸	Yes 2 No	
of Vital Records,  og Physician: The law require  of this certificate has been si meral director, page 2 should	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatien	Othor		Residence 6 Oth	ner:	
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ion itendi leath. for: / the fi	ᆲ	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No				
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification;	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City	
Di To the Hospital. within 24 hours a To the Funeral I	ज़	29a. Certifier (Check only one) 2 Medical Examiner:On the basis of examination and/or investigated and manner stated.					
F s F o	Ĭ	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	fonth, Day, Year)	
		CarolHellair	O.C.M.E.		December 5, 20	008	
-		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	1			
Sta	~~		Carro		•		
Registr		OCME					
DHMH 17 Rev 1/200	11	ORIGINA	AL .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 3, 2008 **Physician** 5:55 A M MaryAnne Folk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1799 Regents Park Road East Crofton If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 💢 F 69 Director 29, 1939 223-50-5219 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County injury or other traumatic event, the Medical Expression must be notified at X Yes 2 No Directo Anne Arundel Crofton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21114 by Funeral 1799 Regents Park Road East USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arleen Wenger ျှ David Raymond Herr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health al Important: If item 27 Is any injury or other trau once. 631 Chapel Gate Drive Odenton, MD 21113 Toni Hetzer/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/4/2008 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service License 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the discrete mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Pancreatic Cancer Days /Medical Due to (or as a consequence of): **Examiner** R/O Renal Cell Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 X No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 □ Yes\_ 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∏Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ours after death.

neral Director: A within 24 hours a To the Funeral L

with the Maryland

28a-f show

ō items 23a

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23

Baltimore, Maryland 21215-0036

Box 68760

P.O.

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

eleve

Laurie Poss, M.D.

DEC 6

D32567

2200 Defense Highway #200 Crofton, MD 21114

12/3/2008

DHMH 17 Rev 1/2001

State

Registrar

Harrit 31. Date filed (Month, Day, Bishop

32. Registrar's Signature

Sidhund 25

Year.

2008

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Cumberland

		For State of Mary  1 - State Registrar		artment of He rtificate of De		ental Hygier	211118	1,0970	
Physic	ion	1. Decedent's Name (First, Middle, Last)		······································		2. Date of Death	Day Year	3. Time of Death	
/Medi		Mary Virginia Gicker				Novembe:	r 30, 2008	7:45 AM	
Exami	ner	4a. Facility Name (If not institution, give street and number) 8147 Bayview Hills Drive		4b. City, Town, or Lo	ocation of Death eake Bea	i	4c. County of Death  Calvert		
Funeral	_	5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea			
Director			86 Yrs.	Months Days	Hours Min.	Mar 29,	1922 LaP1	ata, MD	
and w	]	Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or Loc	cation			10	Od. Inside City Limits	
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th the or 28;	Oire	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Coun	try?	
s 23a	ral	8147 Bayview Hills Drive		2073			USA		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evartings must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married  2 □ Married  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1	Was Decedent of Hisp fYes, specify Cuban, 1 □Yes 2⁄2 No	panic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e Specify: Wh		
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filed I Hygiv	a)	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	Banking en Surname)		
uld be Vlenta rrked tic ev	To B	Thomas Paul Jameson			Cather	rine Mabe	el Hayden		
2 sho and is me		19a. Informant's Name/Relationship (Type. Print)	I	ng Address (Street and			y or Town, State, Zip	<sup>Code)</sup> 20732	
1 and Health Health em 27 ther t		Virginia Lee Hickox (daugh	ter) 814	7 Bayview			sapeake Be		
Pages nent of int: if its		1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cren	natory or other place) on Nat. Cen	Dec.	18	. Myer, V	,	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mance.		21. Signature of Fundal Service Licensee		2. Name and Address	. 200				
2 2 2 E 2 3	ų.	Sary J Goff		3125 Southe					
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t the d by the ached	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year	
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ital or / irs after ral Dire	Certification:	4 Homicide determined building, etc. (8	Specify)			City or Town, Sta	ate)		
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of more and manner stated	amination and/or in	n occurred at the time vestigation, in my opir	e, date and place, a nion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)	
To 1 With To 1	Σ	29b. Signature and title of certifier	M	29c, License n	0629 000	29d. [	Date signed (Morth, I	Day, Year)	
en) 5		30. Name and address of derson who completed cause of death	MARIN	Print	NAU	DOPN,	S. Om	2020	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC - 3 2008	Signature	Spelle					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician December 4, 2008 9:35 A Marie Grove /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Center, Genesis of Waldorf Waldorf Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1□M 2X F 74 Oct. 15. France 1934 Director 564-08-5906 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2724 Pinewood Drive 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pierre Adamiak Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2724 Pinewood Dr. Waldorf, Maryland, Alan J. Grove/ Son 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cemetery Dec 10 2008Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee Willia 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ITASTY LOC disease or condition resulting in death) /Medical Due to (or as consequence of GTHUM **Examiner** Hemse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? Yes 2 No page 2 s certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital

within 24 hours after death.

To the Funeral Director: Af

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only

29b. Signat fre and title of certifier

address of be

Medical

of death (Item 23a) (Type Prin Begistrar's Signature 32.

2008

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated.

29d. Date signed (Month, Day, Year)

Amended #26, n1s, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 12/03/08 State of Maryland / Department of Health and Mental Hygiene Allegany Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11/29/08 **Physician** Month 1:00PM<sub>M</sub> arold Tan le <del>11/29/07</del> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corrigan DR. Corri Ganville

If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 8. Min. N.W. Allegan y

9. Birthplace (State or Foreign Country) 2506 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Year) 219-54-1438 1**X**M 2□F 58 11-21-1950 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner must he marter and any injury or other traumatic event, the Medical Examiner must he marter and any injury or other traumatic event, the Medical Examiner must he marter and any experiments. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Corriganville 1 Ses 2 □ No Allegany Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21524 UR USA Corrigan 12506 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Room Supervisor Tire Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold J& U 104101 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11809 Iowa DR NW Cumberland MD Z150Z /Daughter Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State HYNDMAN CEMETERY 12- Z-2008 HYNDMAN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Linensee 22. Name and Address of Facility HARVEY H. ZEIGLER HOME INC 169 Clarence St HYNDMAN PA 15545 Part . The the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ascvd /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, the action of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, § Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ZER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
Dec 3 2008 29b. Signature and title of certifier 29c. License number D09157 6 MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7770

Registrar

Paul

0 3 2008

31. Date filed (Month, Day, Year)

DEC

Snow,

M.D.

DHMH 17 Rev 1/2001

124 W 3rd ST Cumberland MD 21502

Dpty Med Ex

			For State Registrar	State of		d / Dep		t of H	lealth a		ental Hy		•	409	173
	ą.		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea			3. Time of I	Death
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100	Examin	er	4a. Facility Name (If not institution,				-		Location of			4c. 0	County of Death		
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2.	Funeral Director		5. Social Security Number 216-22-8856	6. Sex 1 🕅 M 2 🗆 F	7. Age (In yrs.	81 Yrs.	Months	Days	Hours	Min.	(Month, Day	v, Year)		place <i>(Stat</i> e or ntry) arv1and	
			Usual Residence of Decedent								NOV. Z	1, 1	921 FI	aryrand	1
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Ž	ss 1 and 2 should to Health and Ment item 27 is marked rother traumatic er		Elizabeth Gles	ssner/Wife	9	696 C	olora	Rd.	, Col	lora,	MD 21	1917			
ore	ges 1 and to the literal or other		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Demoval from 9	20b. I	Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	e) 1	2-08	-2008	20c. Loc	ation - City or T	own, State	
ij	Pages ment of I ant; If Ite ury or o		4 □ Donation 5 □ Other (Sp			Γ. Foa:	rd Fur	nera			1	Ri	sing Su	n, Mary	1and
Baltimore, Maryland 21215-0036	permit. Pag Department Important: any Injury once,		21. Signature of Funeral Service L	icensee A o o	die	2	2. Name an R.T. 111	Foa	ard F	unera	al Home , Risin	, P.A	A. n, MD 2	21911	
d			23a. Pav 1. Enter the discase, or one shock, or heart failure. List of	complications that conly on of use on e	used the dear	th. Do not en	ter the mod	e of dyin	ig, such as	oardiac c	or respiratory ar	rest,		Approximate Interval Betw	veen
-	Physician	П	Immediate Cause (Final disease or condition	_a/			MEU.	MQu	VITT	_				Onset and D	eatn
1	/Medical Examiner	Ш	resulting in death)	Due to (	or as a consec	quence of):					1.00				
8		<u>-</u>	Sequentially list conditions,	b. — Due to (	or as a consec	quence of):									
VD	uted I ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events soulding to detail the sequence of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions o												
o,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (	or as a consec	quence of):									
3760,	ate be executed tysician and he burial-transit	ca		d											
89 ×	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the L	Physician/Medi	IF FEMALE:	20 11											
Box	attend attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		come pr pregn irth 2□Feta ant at time of ∈	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>		,			23	3d. Date of deliv Month	*	ear
P.O.	res that the de signed by the a be detached t	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐Unkno		death 51	_ Other (sp	ecity)							
	s that ned by deta		Part II. Other significant conditio	ns contributing to de	eath but not res	sulting in the u	ınderlying ca	ause giv	en in Part I		23e. Did to	bacco us	e contribute to t	he cause of de	ath?
Records,	w require: been sig should be	ed by				· <del>-</del> ·					1 U Y	/es 2□	No 3□ Pro	bably 4 U	nknown
oce	ne law requ has been je 2 shoulk	Completed									24a. Was autop		24b. Were auto	opsy findings a	vailable
Ä		l e									perfo	rmed?	death? 1 ☐ Yes	2 No	u50 01
Vital	sician; Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	I I a a mit a l				Lou		of Death	(Check only o	ne)			
or	Physical direction	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 124		ER/Outpatie		8c. Injur	4 🗆 NU		me 5 Resid		Other (Speci	fy)	
on	ding P. h. After funer	tion	Natural 5 ☐ Pending investig	(Mont	h, Day Year)	Injury	M	Worl	k?ື Yes 2 □		zod. Describe i	iow injury	occurred		
Division	il or Attend after death I Director:	fica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ot be 28e. Place	of injury - At h	ome, farm, st	reet, factory	, office		- :	28f. Location (S	Street and	Number or Run	al Route Numb	oer,
Ö	talor safte al Dir	Certification:	4 [Tromicide	Dulidi	ng, etc. ( <i>Speci</i>	19)					City or Tow	m, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)	<b>g Physician:</b> To the E <b>xaminer:</b> On the ba and mani	asis of examina	owledge, dea ation and/or ii	th occurred ovestigation	at the tir , in my o	me, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) a date and	and manner as s place, and due t	stated. to the cause(s)	
Ĺ	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	1	/-		290	. Licens	e number	-13		29d. Date	signed (Month,	Day, Year)	
			Manas	A. la	nade	Mas		k	142	800	9	_/	2/6/1	18	
	7		30. Name and address of person v	Ac 1710	anno	NO) :	Print)	in	los i	me	Na	611	10,21	0>8	7
20	Sta Regist		31. Date filed (Month, Day, Year)	.9 2008 32. R	ebistrar's Sign	ature	Good	فسأه			/	/	/		

1015 AM

GEORGIE GLESSMER

#216228856

				artment of Health and M rtificate of Death	lental Hygien	ZUUU 403/4
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Hanako Horsfield  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Decembe	ay Year 3. Time of Death
	Funeral Director		5. Social Security Number 217–60–1668  Usual Residence of Decedent  Color of No. 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Mar. 3, 1	9. Birthplace (State or Foreign Country) Japan
	death with the Maryland ime 23a or 28a-f ehow i must be notified at	Director	10a. State 10b. County 10c. City, Town or Lo	en		10d. Inside City Limits 12€ Yes 2 □ No
	23a or 2	rai Dir	10e. Street and Number 104 N. Post Rd.	10f. Zip Code 21001	1	itizen of What Country? Japan
5-003e	or its	d by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Asian
1-61212	l within 7 iene. r than "n ine Ned	Completed	(Specify only highest grade completed) (Give life. Sementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) emaker	16b.	Kind of Business/Industry  In home
yland	정혈호	To Be (	17. Father's Name (First, Middle, Last) UNK	18. Mother's Name UNK	(First, Middle, Maide	n Surname)
re, mar	ges 1 and t of Health If item 27 or other ti		William H. Flowers (POA) 1013  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1013	Warwick Dr. Apt 2  Station (Name of matory of other place)  Mem. Gdns. 12/15	2-B Aberd	or Town, State, Zip Code) een, MD 21001 .ocation - City or Town, State rdeen, Maryland
Dairimo	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licensee	2. Name and Address of Facility arring—Cargo Funera	al Home, P	.A.
b	by be executed by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the burial-transit by the	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	perdeen, Maryland ter the mode of dying, such as cardiac of the mode of dying.  Aney Disease	or respiratory arrest,	Approximate Interval Between Onset and Death
O. BOX 08/0U,	ath certific attending p for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
GS, T.	uires that t signed by Id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
al necor	: The law requires that the cate has been signed by th page 2 should be detache	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Sion of Vital	To the Hospital or Attending Physicien: The law requires that the de within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached to completely filled in by the funeral director, page 2 should be detached.	ation; To Be	25. Was case referred to medical examiner?  1		Check only one) ne 5 ☐ Residence 28d. Describe how inju	
2	ital or Att rrs after de rel Direct ied in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, Stat	
	the Hospital hin 24 hours a the Funerel hpletely filled	Medicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death one)  Medical Examiner: On the basis of examination and/or invalid	vestigation, in my opinion, death occurre	ed at the time, date an	d place, and due to the cause(s)
	with To		29b. Signature and title of certifier  Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manual Manua	29c. License number D19583	De C	ember 13,2008
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	of term >)	reet x	be idean
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 2 2008  32. Registrar's Signature	1		

Amended #1, nls, per phy., 12/03/08, Allegany Co. 1 - For State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate	of Death	
OGI IIIIGAIG	UI Dealii	

008

40375

**Physician** /Medica Examiner

**Funeral** 

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f show Department of Health and Mental Hygiene. Important: If tem Z7 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experient once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

an	1. Decedent's Name KENNETH	Y-DALE H						2. Date of Do	Day	Year	3. Time of Death
al			street and number)		1	41. C'h. T	. Landing of Door	NOVEMBI			
er			I				or Location of Deat ERLAND	ın	4c. C	County of Dea ALLE(	
	5. Social Security N	BRADDOCK umber 6. Se		e (In vrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth		thplace (State or Foreign
	214-28-69	34	<b>XX</b> M 2□ F	8	Vre	Months Days	C	ountry) MD			
	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limits
ţo	PA	Bedford		Hvi	ndman					1 □Yes 2 No	
)irec	10e. Street and Nun	nber				10f. Zip Code			10g. Citize	en of What Co	ountry?
je.	2705	Second Av	ve.			155	45		US	Δ	
nuel	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13. V		lispanic Origin? (S an, Mexican, Puer	Specify Yes or No		4. Race - Ame	
Be Completed by Funeral Director	1 ☐ Never Marrid		1 □Yes 2 □ I If Yes, Give Year or Dates:	1945-		□Yes 2□XNo	Specify:			Black, Whit Specify:	White
ted	-	15. Decedent's Edi	ucation		16a. Deced	ent's Usual Occup	pation		16b. Kind	d of Business	
nple	Elementary/Secon	ify only highest grad ndary (0-12)	de completed) College (1-4or 5		(Give I life. D	kind of work done PO NOT use retire	during most of wor d)	rking			
Co	12				Lal	orer				ing Co	mpany
17. Father's Name (First, Middle, Last)  Ralph Lester Hite  Ralph Lester Hite  Ralph Lester Hite											
19a. Informant's Name/Relationship (Type. Print)  Mary Platt/ Sister  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  126 John St., Hyndman, PA 15545										Zip Code)	
	20a. Method of Disposition  20b. Place of Disposition (Name of comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison of City or Town, State comparison										Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hyndman Cemetery 11-26-2008 Hyndman PA											
21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Harvey H. Zeigler Funeral											neral
	- All	ee &	Udano				, 169 CI	arence	St Hy.	ndman	PA 15545
	snock, or near	t failure. List only o	lications that caused one cause on each lin	the death ne.	. Do not ente	r the mode of dyi	ng, such as cardiad	c or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (I disease or condition resulting in death)		a. SEPSIS								Onset and Death  10 DAYS
	,	- 1	Due to (or as	AND SHEWAR	er eneman						
ě	Sequentially list con dany, leading to mic cause. Enter Under	ditions,	b. RECENT Due to (or de			E REPLAC	EMENT				4 WEEKS
amir	that initiated events	njury	C.								
cian/Medical Examiner	resulting in death) L	ast	Due to (or as	a consequ	ence of):						
dica			d					<u> </u>			
Me	IF FEMALE:		23c. If yes, outcome	of pregnar	ncv				T.,		
ciar	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐	nonths?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗆 Fetal	death 3	Ectopic pregnance Other (specify)	у		23	d. Date of del Month	Day Year
Physic	9 Unknown		9 Unknown			,,,,,,					
by P			entributing to death be	it not resul	ting in the und	derlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ted	METABOLIC	ENCEPHAL	OPATHY					1 🗆	Yes 2D	No 3□ Pr	obably 4 🗍 Unknown
Completed	RENAL FAI	LURE						24a. Was autoj	osy	24b. Were au	topsy findings available completion of cause of
			ERY DISEA	SE			perfo 1 □ Yes	rmed2 2 No	death? 1 ∐ Yes	2  No	
25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
١	27. Manner of Death	40	28a. Date of Inju		R/Outpatient 28b. Time of	3 DOA	4 LI Nursing H	ome 5 Resi	_		cify)
atio	1 Natural 2 Accident	5 Pending investigation	(Month, Day	i, Year)	Injury	28c. Injur Worl	ໃ?ົ່ Yes 2 ∐No	Log. Boombe	ion injury c	ocurred	
Įį į	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju	ry - At hor	ne, farm, stree	et, factory, office		28f. Location (; City or To	Street and I	Number or Ru	ral Route Number,
Č		<b>V</b>	N.				1)				
Medical Certification: To	29a. Certifier (Check only one)	Certifying Phy	vsician: To the best of iner: On the basis of and manner sta	examinati	rledge, death on and/or inve	occurred at the tirestigation, in my c	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
Me	29b. Signature and t	itle of certifier	R			29c. Licens	e number			signed (Monti	
		V. H.Kan	11 Theo			D193	18		/V	N 25	th 2008
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								12	-	

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 3 2008

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland	/ Depa	artment <i>rtificate</i>	of H	ealth a Death	and M	lental Hy	giene Reg. No	-	8	40	376
			Decedent's Name (First, Middle, Last	)							2. Date of De	ath	-		3. Time o	of Death
Н	Physici /Medic		Reginald	Mor	nroe		Hai	rris	Jr.		Month Decem	Da Iber		Year 008	1400	РМ
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or	Location o	f Death		7	. County o		1100	
ı			Allegany Co. Nurs	ing & Reha	ab Cei	nter			Cumbe					A11	egany	
	Funeral		Social Security Number     6. Se		(In yrs. las		If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	(Month, Da	ay, Year)		<ol><li>Birthp Coun</li></ol>	lace (State try)	or Foreign
	Director		152-05-0968 '5' Usual Residence of Decedent	4 201	91	Yrs.					05/19/	191	7	New	Jerse	у
	and and		10a. State 10b. County	1	10c. City, 1	Town or Lo	cation							1	Od. Inside (	City Limits
	Mary feh	ō	MD Alle	gany			LaVal	е							1 🗀 Ye	s 2 1 No
	r 28a	rec	10e. Street and Number				10f. Zip (	Code				10g. Ci	tizen of Wi	nat Coun	try?	
	3a or	Funeral Director	356 National	Highway				2	1502				US	A		
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race			
٥	be filed within 72 hours after death with the Maryland Hygiene Hygiene dother than "natural", or items 23a or 28a-f ehow dother than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	F.	1 ☐ Never Married 2 ☐ Married	1 ⊕Yes 2 ☐ No	°1941 <b>-</b>	1	Tes, speci		Specify:	, Fueito i	rican, etc.)		Specify:	, White,	HC.	
215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1946									Whi		
Ÿ	"nati	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		(Give	ient's Usual kind of work DO NOT use	done di	urina most	of workii	ng	16b. K	ind of Bus	iness/Inc	ustry	
7	withir ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+	-)		sic Ed	,				, n	1. 3 • -	G 1	-	
N 0	filed Hygi sther		17. Father's Name (First, Middle, Last)			Mus	SIC EO			r's Name	(First, Middle		ublic Sumame		tools	
and	Mental Mental arked c	To Be	Reginald	Monroe	Har	ris,	Sr.		Oli	ve		Leo	na	Wi	llian	ns
Mary	R P E E	-	19a. Informant's Name/Relationship (T)		1						l Route Numb			tate, Zip	Code)	
	- E N =		Gwendolyn H. Harr:	is / Wife			-		L High	hway	, LaVa	le,	MD 2	1502	!	
o e	- I P E		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	Removal from State	cem	etery, cren	sition (Name natory or oth	her place	· I		ate		ocation - C			
Ĕ	Pages ment of tant: If it lury or o		`4 □Donation 5 □ Other (Specify)		Cumb						/2008					
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	and							ms Fam: , Cumbe				lome, 1502	P.A.
			23a. Part . Enter the disease, or compleshock, or heart failure. List only o	ications that caused t	he death.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition	Caran	and	Al	-	Dn	sea	28					Onset and	
	/Medical		resulting in death)	Due to (or as a	consequer	nce of):	and a	- 41	3 000						ING	
	Examiner		Sequentially list conditions.	b			(M)									
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequer	nce of):										
	and I-tran	каш	that initiated events resulting in death) Last	c. Due to (or as a	consequer	ace of):										
8/0C,	ficate be executed physician and as the burial-transit	回田		D00 10 (0) as a	CONSEQUE	100 01).										
28	phys the	dical		d												
×	death certificate e attending phys d for use as the	Physician/Me	IF FEMALE:	23c. If yes, outcome o	f pregnanc	v							23d. Date	of delive	0/	
X P P	atter of for u	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal de	eath 3	Ectopic pre						Monti		,	Year
j.	e 4 5 1	hysi	1  Yes 2  No 9  Unknown	9□ Unknown												
ري ح	w requires that the sbeen signed by the should be detact	by P	Part II. Other significant conditions con	ntributing to death but	not resulting	ng in the un	iderlying cai	use giver	n in Part I.		23e. Did t	obacco i	se contrib	ute to the	e cause of	death?
cords	an sig	edit									1 🗆 '	Yes 2	No 3	☐ Proba	ably 4 🗌	Unknown
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Ĭ	reician: The law s certificate has b lirector, page 2 sh	Completed									autor perfo	rmed? 2X No	dea	ath? Yes		Jause of
N I I I	ian: rtifica	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	<del></del>				
5	hyeic nis ce I dire	To I	1 ☐ Yes 2 No	lospital: 1 🗌 Inpatien	t 2□ER	VOutpatient	3 DOA	Other	4 Nur	sing Hon	ne 5 ☐ Resi	dence	6 □Other	(Specify	)	
	ng P	ü	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	3b. Time of Injury	28	c. Injury : Work	at	2	8d. Describe	how injut	y occurred	i		
<u>0</u>	tendi eath. for: A the fu	cati	2 Accident investigation				М	1 🗆 Y	es 2□N	10						
DIVISION	or Atl	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home (Specify)	e, farm, stre	eet, factory,	office		2	8f. Location (i City or To	Street an wn, State	d Number )	or Rurai	Route Nun	nber,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy.	sician: To the best of	my knowle	edge, death	occurred at	t the time	e, date and	place, a	nd due to the	cause(s)	and mann	ner as sta	ited.	
	n 24 h n 24 h ne Fu sletely	edical	(Check only 2 Medical Exami	ner: On the basis of e and manner state	examination	and/or inv	estigation, i	n my opi	nion, death	h occurre	ed at the time,	date and	place, an	d due to	the cause(s	s)
		Ž	29b. Signature and title dicertifier					License		0		29d Dai	te signed (			
	5+		pol	ma				000	332	86		NE		1,	2008	<i>-</i>
			30. Name and address of person who co	ompleted cause of dea	ath (Item 23	За) (Туре, Г	Print)									
	nols		Sunil K. Gup				Avenu	ie, (	Cumbe	rlan	d, MD	215	02			
	Sta Registra		31. Date filed (Month, Day, Year)  NFC 0 4 2008	320 Registrar	's Signature	Som	reles									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Donald Ray Harden 12 8:25P 07 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13409 Reed Rd NW Allegany Mount Savage 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours 70 214-34-1348 01 - 14 - 1938PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD **Allegany** Mount Savage Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21545 USA 13409 Reed Rd NW Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White etc. 1 ☐ Never Married 2 X Married NXYes 2□No If Yes, Give Year or Dates: 1955–58 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Alberta Bloom William Edward Harden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice L. Harden / Wife 13409 Reed Rd NW Mount Savage, MD 21545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-11-2008 Flinstone, MD Rocky Gap Veterans 4 Donation 5 Other (Specify) 21. Signature Fineral Service Licenses 22. Name and Address of Facility Harvey H. Zeigler Funeral adam Home Inc 169 Clarence St Hyndman PA 15545 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythmia /Medical Due to (or as a consequence of) Examiner Asbestosis 6 years Sequentially list conditions, if any, leading to immediate cause. Errer Universing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease 6 years nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Coronary Artery Disease 4 months IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Meilitus 24a. Was an Was c... autopsy performed? Ves 2 ANo certificate ha 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death after death.

I Director: After to in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 D0025296 12-8-2008 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) MXX Crossland MD 200 Glenn St. Cumberland MD 21502 Stephen P. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 0 9 2008 parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#30perDVR, G886, 12/22/08, WS State of Maryland/ Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Charlotte Lorrain Ignacio 2:38 PM December 11,2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔽 F Months Days Hours Min. 69 139-30-6875 1939 April 6, Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 10419 Sharpsburg Pike U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Conner William Conner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16727 Long Street Dr. Williamsport, MD 21795 Thomas L. Haws, Sr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State December 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2008 13. 21. Signature of Funeral Service License 22. Name and Address of Facility J.L. Davis Funeral Home Je Be MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Examiner Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event in any injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or other traumatic event in the manual or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or injury or in

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		24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No		
25. Was case referred to medical	26. Place of Deal	h (Check only one)		
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ne 5 Residence 6 Other (Specify)		
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury occurred		
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) Medical Exa	Physician: To the best of my knowledge, death occurred at the time, date and place siminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)		

29c. License number

0060228

State Registrar

Ahmed

12821 Oak Hill Ave.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, Md. 21742

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Sigrature and title of certifier

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** VIRGINIA **JOHNSON** 12/07/2008 9:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester 5821 Onley Road Girdletree If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 6. Sex 8. Date of Birth (Month, Day, Year) 05/11/1924 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 84 Director 117-14-8095 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐Yes 2X No Director MD Girdletree Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 21829 LISA 5821 Onley Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. 3 27 is marked other than " Elementary/Secondary (0-12) 12 College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Vincent Conerty, Sr. Rose Veronica Mundy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trauonce. Barbara Harrison (daughter) 5821 Onley Road, Girdletree, MD 21829 Baltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery 12/10/2008 Girdletree, MD 22. Name and Address of Facility
Holloway Funeral Home, Professional Association
103 Linden Ave., Pocomoke City, MD 21851 21. Signature of Funeral Service Licensee ean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORDIOMYOPATA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unverlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9☐Unknown 9 ☐ Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy this certificate 2 No 1∏ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifies 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) o como Ke ILNTh Lac 65 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

08-09	9446
Paul	Kindle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ul Killule		-For State Criticate of Death	5,116 1., g. 61.16	Reg. No.	U0 4 3 3 0
Physicia edical Examir	n/	Registrar  1. Decedent's Name (First, Middle,Last)  Paul Richard Kindle	2. Date of I Month Decem	Death Day Year ber 15, 2008	3. Time of Death 0545 hrs
Eultai Lxaiiii	_	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 2326 Belair Road  Baltimore		4c. County of Dea	ath .
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	ours Min.		Birthplace (State or Foreign Country) Maryland
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	ğ	Maryland     Baltimore     Baltimore       10e. Street and Number     10f. Zip Code		10g. Citizen of What Co	1 X Yes 2 No
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Com	17. Father's Name (First, Middle, Last) 18.Mo	other's Name (First, Mid	dle, Maiden Surname)	aping
2121 Ild be fill Mental H marked	o Be	William L. Kindle  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and		V. Himes  Number, City or Town, St	ate, Zip Code)
MD ;		Verna L. Kindle (Wife) 4316 Belair Rd.		, Maryland 2	
imore, MD 21215 Pages I and 2 should be file ment of Health and Mental Hy tant: If item 27 is marked o or other traumatic event, th		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	) Decembe	er	rg, Maryland
Baltimore, permit, Pages I an Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Fa	acility $J.L.$	Davis Funer mithsburg, M	
Physician	-	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.			Approximate Interval Between Onset and
/Medical :aminer		Immediate Cause (Final disease or condition resulting in death)  Carbon monoxide Toxicity  Due to (or as a consequence of):			Death
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	ysician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Edge of the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	ctopic pregnancy	Month	Day Year
P.O. Bo	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23e.	Did tobacco use contribute  Yes 2 ✔ No 3	e to the cause of death?  Probably 4 Unknown
ords, P.C.  w requires that s been signed I should be deta	eted				e autopsy findings available to completion of cause of
Reco The law cate has	Completed			performed? deat Yes 2 ✓ No 1	h? Yes 2 No
Vital Rec ysician: The I his certificate I director, page	o Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  26. Place of D  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othe	Death (Check only one) er4 Nursing Home	5 Residence 6 C	Other: Scene
n of \ding Phy ding Phy After the		27. Manner of Death  1 Natural 5 Pending  128a. Date of Injury Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Power Pow	- Exposu	cribe how injury occurred ire to carbon monox	ide fumes
Division of Vital Records, To the Hospital or Attending Physician: The law requir whith 24 hours after death. To the Funcal Director: After this certificate has been s completely filled in by the funeral director, page 2 should b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be Dec 15, 2008 10500 hrs  28e. Place of Injury - At home, farm, street, factory, office building	ing, etc. 28f. Loca or To	ation (Street and Number of own, State) lair Road, Garage #5, E	r Rural Route Number, City
Hospita 24 hours Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date at	and place, and due to the	e cause(s) and manner as	stated.
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, decard manner stated.  29b. Signature and title of certifier / 29c. License nur			(Month, Day, Year)
		Carde Hallan O.C.M.E	<u> </u>	December 15	, 2008
le		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	, MD 21201		
S Regis	tate	0.000 80- 250- 250- 250- 250- 250- 250- 250- 25		-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Deconta 2008 Year Stephen Michael Krembs 5:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5431 Beach Drive St. Leonard Calvert Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Aprili Day, Year 948 396-46-0938 60 Months Days Hours Min. 1 XM 2 F Wisconsin Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Virginia | Alexandria Alexandria 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 South Union Street 22314 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 2 No 1 Never Married 2 Married <sub>Specif</sub> white 3altimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Gollege (1-4or 5+) Elementary/Secondary (0-12) contract specialist FDIC Finacial 17. Father's Name (First, Middle, Last) John Krembs 18. Mother's Name (First, Middle, Maiden Surname) Mary Felker ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 South Union Street Alexandria Virginia 22314 Donna Carroll Krembs- wife 20b. Place of Disposition (Name of cemetery, crematory or other place Dec 3,2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department o Important: If any injury or Alexandria Virginia Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home ature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 months Immediate Cause (Final **Physician** Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown 9 Unknown à signed k I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bowel Obstruction 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 🛂 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other:  ${}_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\square$  Other (Specify) 2nd home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide i 24 hours af 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062100 December 02,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dung Le 1650 Orleans Street Room 407 Baltimore Maryland 21231 31. Date filed (Month, Day, Year) 32. Registrans Signature State 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, **Physician** 11:38P <sup>™</sup> William L. Knights November 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing Home Prince George's Bowie 8. Date of Birth (Month, Day, Year)
Jan. 14, 1919 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Dakota **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 89 Jan. **Director** 476-10-7294 Usual Residence of Decedent with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinar instanting ones. 3800 Enfield Chase Court #200 20715 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u></u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Specialist Printing & Engraving 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Timothy O. Knights Lena Hoffmeister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Knights/ Wife 3800 Enfield Chase Court #200 Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 12/4/2008 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Chronic Myeloid Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ð Hypertension 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ANursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗓 No မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45217 12/3/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIO Adebowale Ajayi, M.D. 6201 Greenbelt Road #M13 College Park, MD 20740 Registrar's Signature 31. Date filed (Month, Day, Year) 32. State DEC 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Legeer 4, 2008 1328 P December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15908 Meadowdale Drive Rawlings Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Months Days Hours 213-40-4056 66 11/27/1942 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Rawlings Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21557 15908 Meadowdale Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1963 — If Yes, Give Year or Dates: 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 Ballistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Legeer Dorothy Mae Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra K. Morris / Sister 20901 Old Williams Rd, SE, Flintstone, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 12/6/2008 4 Donation 5 Dother (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signafure of Funeral Service Lice 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy pertormed? 1□ Yes -2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D17565 December 5, 2008

State

3

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical

**Physician** /Medical

**Examiner** 

attending physician and for use as the bunal-transit

Division or Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) DEC 08 2008 egistrar's Signature

Jr., M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Bollino,

Registrar

922 National Highway, LaVale, MD

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 12 Vatricia Lono 1537 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore umma If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Days Hours 62 Yrs. Director 221-34-3261 02/10/1946 DE Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene.

The 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18140 Henderson Rd. Funeral Lot 21649 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo ģ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ William Frank Long, Sr. Dorothy Mae Bedwell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Parker/daughter 616 Main St., Marydel, MD 21649 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sudlersville Cemetery 12/10/2008 Sudlersville, MD 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
106 W. Sunset Ave., Greensboro, MD 216 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Falure /Medical Due to (or as a consequence (if): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Intracerebral Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Greene St. Baltimore, MD 21201 Heather Sheet3 22 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

of Vital Records, P.O. Box 68760,

Division

2 2908

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Homer Francis Lemmon December 2008 3:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11080 Weymouth Court Waldorf Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 4, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 94 West Virginia Director 232-03-8514 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at XXYes 2 □ No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 11080 Weymouth Court 20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>6</u> Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Mayflower Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Lemmon Maude Poe 19a. Informant's Name/Relationship ( pe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Diane Goldstein/ Daughter 2701 Monocacy Ford Rd. Frederick, MD. 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State **Huntt Crematory** Dec. 7, 2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee A all m00544 3035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Justo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): physician a Box 68760. Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign be disorde s been signated b 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Embolism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate ! Division of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes ➢️ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 5 ☐ Pending investigation of Funeral Director: A Funeral Director: A letely filled in by the fu r death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

State Registrar rate

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

#102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rodney Glenn Lindstrom December 2008 3:30A /Medical 4a. Facility Name (If not institution, give street and number)
13235 Linvery Place 4h City Town, or Location of Death 4c. County of Death **Examiner** Newburg Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nin. | December 27,1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√**M 2□F 218-54-7314 61 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Enatural must be notified at Director 1 □Yes 2 No MD Charles Newburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. ther than "natural", or items 23a or 13235 Linvery Place 20664 USA Funeral Was Deceu Armed Forces? Ves 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 TNo If Yes, Give Year or Dates: Specify White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paper Hanger Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I Paul Glenn Lindstrom Esther F. Byrd-Clegg ည and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Wayne Lindstrom/Son P.O. Box 1 Newburg, MD 20664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 12/8/2008 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) M0094521. Signature of Funeral Service Licensee 22. Arehart Echois Funeral Home, P.A. Echilo Kewil 211 St. Mary's Aye. La Plata,MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 □ Yes 2 □ No Year Month Day the 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The performed? 1 ☐ Yes 2 ☐ No certificate 2 🗆 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

To the I within 2 To the I

Division of Vital Records, P.O. Box 68760.

Saltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARAKSHIBAIG HD . 6620 CRAIM 32. Registrar's Signature

> **DEC 08** 2008

. 6620 CRAIN

State

Registrar

29c. License number

00056949

HWY, STE 102

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend P1 1 ine a - b, & 25, per ME 8895 9/10/09 TT

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year LACY LATTIMORE 0505 Dec 4c. County of Death 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Salisburu Wicomico Salisbury Rehab & Nursing Ctr. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 12 M 2□F 8. Date of Birth (Month, Day, Year) 3–15–1928 9. Birthplace (State or Foreign Days Months Hours Min. 80 GEORGIA 257-04-2226 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WORCESTER WHALEYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11801 SHEPPARDS CROSSING ROAD 21872 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify BLACK Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMING FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JERRY LATTIMORE LEORA ROBERTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE HARRISON/SISTER P.O. BOX 17, WHALEYVILLE, MARYLAND. 21872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State MELSONS CREMATORY 12-13-08 FRANKFORD, DELAWARE 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligensee MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST, FRANKFORD, DE. 23a. Part 1 Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest immediate Cause (Final disease or condition resulting in death) lad Due to (or as a consequence of): Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NTION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): CERTIFIC IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1∐ Yes 2 THNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 3□ DOA 1 X Yes <del>2 ☐</del> 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed or Vital Records, Division or Attending within 24 hours arter control to the Funeral Director: Aft Hospital

O. Box 68760,

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State Registrar

Physician

/Medical

Examiner

**Funeral** 

Director

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Department of Health and Mental Hygiene important: If Item 27 Is marked other than "nature any Injury or other traumatic event, the Medical ones."

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/Medical

Examiner

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Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed

Examiner must be notified at

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Certification:

Medical

Illiam 31. Date filed (Month, Day, Year) DEC 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins, M.D.

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Marion Stevens Molten December 14, 2008 4b. City, Town, or Location of Death 4c. County of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician /Medical 7:11 P 4a. Facility Name (If not institution, give street and number) Examiner 12941 Little Hayden Circle Hagerstown Washington 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 🖫 F Hours 129-16-0447 Yrs. Director 92 May 15, 1916 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director Maryland 1√2Yes 2 □ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or? 12941 Little Hayden Circle 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Completed by 1 ☐Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph C. Stevens ဂ Helen Pecor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 12941 Little Hayden Circle Hagerstown, MD 21742 Robert P. Molten III 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December Smithsburg Crematory Smithsburg, Maryland 15, 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1em /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): the attending physician hed for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Yes 2 No 4 Pregnant at time of death Month signed by the a Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X No page 2 should Completed 1 🗌 Yes 3 Probably 4 Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate performed 2 No 1 □ Yes 2 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Seath 1 Defatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier nd manner stated 29b. Signature and title of certifi-5 ddress of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 P.O. Box 68760, of Vital Records, Division 22511 31. Date filed (Month, Day, 32. Registrar's Signature State DEC 2 2008 2 Registrar

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21215-0036	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Mean Examiner must be nuitified at	al	4a. Facility Name (If not institute 231 Tate Road  5. Social Security Number 217-40-2926  Usual Residence of Decedent  10a. State 10b. Count MD Calve  10e. Street and Number 231 Tate Road  11. Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3	6. Sex 7. A  1 A 2 F  ty  ent  12. Was Decedent Armed Forces 1 Yes 2 (2) (1798 G)	ge (In yrs. la.  10c. City, Princ	65 Yrs. Town or Loce Frede	10f. Zip Code	ederick  If Under 24 F Hours M  20678  dispanic Origin? an, Mexican, Pu Specify:	Decembers  Irs. 8. Date of Bi (Month, Di July 15,  (Specity Yes or No erto Rican, etc.)	der 1,  4c. Cour  Calver  th  1943  10g. Citizen o  USA  14. R	ty of Death t  9. Birthp Cour MD  1  f What Coun ace - Americack, White, a	0d. Inside City Limits  1 □ Yes 2 ☒ No  try?  an Indian, etc.
	2 should be filed within n and Mental Hygiene. is marked other than "raumatic event, the Men	To Be Comp	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle E 19a. Informant's Name/Relation	e, Last) Estep Mackall	5+)	Heav	vy Equipmen	t Operator 18. Mother's N	lame (First, Middle A Rural Route Numb	, Maiden Surna nnie Hawk	ins	
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		Jane Willett - Frie  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service	n 3 □ Removal from State (Specify)	'	nce of Dispo metery, crer nestine	sition (Name of matory or other pla Jones Ceme 2. Name and Addre	etery 12	Date /6/2008	20c. Location	eake Be	wn, State ach, MD lerick, MD 20678
,00	Physician /Medical Examiner  e pe executed physician and physician and physician	cal Examiner	23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	line.	ence of):	ter the mode of dyi	ng, such as card	liac or respiratory a	-3	9	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1  ☐ Live birth 4  ☐ Pregnant 9  ☐ Unknown	2 Fetal d	leath 3	□ Ectopic pregnand □ Other (s <i>pecify</i> ) _	cy			ate of delive	pry Day Year
Vital Records, P.	e law requires that the de has been signed by the a je 2 should be detached f	Completed by Pł	Part II. Other significant condi CORDNAR DIABE	tions contributing to death ARTE				ven in Part I.	23e. Did 1 1 1 24a. Was auto	Yes 2 No an 24b	3 ☐ Prob	ne cause of death?  ably 4 Unknown  psy findings available  inpletion of cause of
ivision of Vita	tending Physiclan: leath. tor: After this certific the funeral director, I	Certification: To Be Con	3 Suicide 6 Could	Hospital: 1 □ Inpat  28a. Date of Inj (Month, D)  tigation d not be  28e. Place of In	ury 2 ay, Year)	28b. Time of Injury	Wor	ner: 4 □ Nursing	1 □ Yes Death (Check only of Home 5 □ Presi 28d. Describe	dence 6 00 how injury occu	death? 1 Yes	2 No
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical Medical	1 einsh	of examination tated.	on and/or in	vestigation, in my	se number	ccurred at the time,	date and place 29d. Date sign	e, and due to	Day, Year)
dev	Sta Registr	te ar	30. Name and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person a	in who completed cause of municipal state of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of t	death (Item 2 M.).	re	Print) Di CSP 17	n L R	D PRIM	ree f	RED	ERICK HND 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year Kathleen Marie Morris 4,2008 ecember /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Year 1 □ M 2 🕅 F Director 214-42**-**4704 Feb. 1944 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Macheal Expraired must be notified at 1 ☐ Yes 2X No Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12013 Augusta Drive 20769 **USA** Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify Š Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Contract Specialist Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, It once. Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Pages 1 and 2 should be Charles Webster Knox, Jr. JORENS , ပ Reba Dolores Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick John Morris/husband 12013 Augusta Drive Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 12/06/08 Odenton, MD 21. Signature of Funeral See 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o Approximate Interval Between Onset and Death Immediate Cause (Final ANKE 12 **Physician** UNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a, Was an autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD58182

15 EG

State

Registrar

7500 Hanover Parkway,

Suite #101A Greenbert, md. 20170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32.

Caistrar's Signature

George

Do

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 04:05 AM Physician DECEMBER 2008 MORELAND 03 DAVIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth
(Month, Day, Year) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 □ F 219-28-6388 Maryland 77 1931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. Annapolis 1 Yes XXNo Maryland Anne Arundel Director 10f. Zip-Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 1030 Harbor Drive 21403 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 1 1 Yes 2 □ No
If Yes, Give
Year or Dates:1952-54 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Rogers Benjamin Moreland ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Moreland/wife 21403 1030 Harbor Drive Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Gurial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 12/8/2008 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Fyneral Service/Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ANTERIOR MYDCARDIA /Medical Due to (or as a consequence of): **Examiner** CUTE COPONA Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed nding physician and use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month fo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 TYes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No 1 Tes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Dhpatient ၉ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗀 No 2 Accident after death Director: A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Dla completely filled in Hospital 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Kes-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH:17 Rev 1/2001

State

Registrar

USTIN

31. Date filed (Month, Day, Year)

DEC 0 5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-09148 2008 40992 State of Maryland / Department of Health and Mental Hygiene Charles William Nelson 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death B. Time of Death Physician/ Month Day December 5, 2008 1527 hrs Medical Examiner William Charles Nelson 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cumberland Allegany 217 Virginia Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Maryland
Country) Months Days Hours Min Director 215-42-4450 06/11/1946 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State Ruy 1 X Yes 2 No Cumberland or items 23a or 28a-f show Allegany must be notified at once. hours after death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number 217 Virginia Avenue 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Never Married 2 X Married 1 X Yes 2 If Yes, Give Year Vietnam Yes 2 X No specify: Widowed Specify: White event, the Medical Examiner Divorced "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) timore, MD 21215-0036

1 Pages 1 and 2 should be filed within 72 h

Tunent of Health and Mental Hygiene. marked other than 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Pauline Ullery 0aker George Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tant: If item 27 is m 22011 National Pike, NE, Flintstone, MD 21530 Judy L. Nelson / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 12/8/2008 Cumberland Crematory Cumberland, MD mportant Other Specify Donation 5 22. Name and Address of Facility Adams Family Funeral Home. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 Pinf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Stab Wound of Chest Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical tending physician a use as the burial -AMENDED UNPENDED of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed by 2 should be detached ģ Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate Yes 2 Yes 2 1 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 this ٩ 1 V Yes No 28a. Date of Injury FOUND: Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed self FOLIND: Division Natural Pending Yes 2 ✔ No hours after death. within 24 hours after death To the Funeral Director: the Dec 5, 2008 1518 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 217 Virginia Avenue, Cumberland, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCME December 6, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Dillivii | 17 Rev 1/2001 **OCME 2006** 

State

Registrar

Donna M. Vincenti, MD

82008

12. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 17 ERBER he 7, 2008 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Season's Hospice @ Northwest Baltimore Randallstown 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Director 240-50-9348 Nov 3, 1936 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examiner must be notified at once. Director 1 ☐ Yes 2 No MD Columbia Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5633 Open Sky 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Description of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second o 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Defense Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Lee Pass, Sr. Georgia Etta Hedrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Simon Pass/ wife 5633 Open Sky Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 12/09/08 Odenton, MD 21. Signature of Funeral Service 22. Name and Address of Facility Going Rome Cremation Service P.O. Box 784 MO125 LBeverly L. Heckrotte, P.A. Clarksville MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy 2 100 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 💆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Pay, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation NI A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 31. Date filed (Month, Day, Year)
DEC 0 9 gistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Judith Piper Ann 2 2008 0315 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITA YUAGANY CUMBERLAND 8. Date of Birth (Month, Day, Year) Dec 12, 1944 5. Social Security Number 7. Age (In yrs. last birthday) f Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ **y**F Hours Min. 215-44-7708 Director 63 МD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Oldtown ral", or items 23a or 28a-f sh Examiner must be multified Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15709 Ruby Road SE 21555 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □N Specify: 3 Widowed 4 Divorced Specify: white other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) secretary/manager National Nabisco Co. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot any Injury or other traumatic even James Raymond Piper Nellie Frances Vance Piper ပ 19a. Informant's Name/Relationship (Type. Print) Roger Piper Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15506 Old Oldtown Road Oldtown MD 2 brother MD 21555 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/5/2008 4 ☐ Donation 5 ☐ Other (Specify), Cresaptown MD 21. Signature of Funeral Service Licen, ee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Immediate C-use (Final disease or undition resulting in death)

a. The LED

Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the con Physician weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of):  $\pm \alpha \chi + \omega \mathcal{M} \mathcal{E} + \chi \mathcal{A} \mathcal{A}$  Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: A 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 4 ☐ Pregnant at time of death Day Year 5 Other (specify) ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 2 40 1 □Yes 25. Was case referred to medical examiner?
1 Yes TO No. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman M.D.  $\infty$ P SETON DR. CUMBERLAND, ND 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 19

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	——————————————————————————————————————		rtificate of			eg. No.	. 1333
П	Physicia	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Merle Meadows Port  4a. Facility Name (If not institution, give			4h City Town or	r Location of Death	December	4, 2008 4c. County of Dea	10:11 AM
1	Examin	ier	Civista Medical Ce			La Pl			Charles	ui
Ī	Funeral		5. Social Security Number 6. Se	X 7. Age (In y	rs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 12,		thplace (State or Foreign
	Director		Usual Residence of Decedent	95	Yrs.			Feb. 12,	1913   Wes	t Virginia
	yłand how		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Mai	Director	Maryland Charle	s	Brandy					1 □ Yes 2 XNo
	with th	Ö	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	ountry?
	ms 23	Funeral	15930 Woodlark Dri	12. Was Decedent Ever in	U.S. 13. 1	20613 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ame	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Evan, including the infilted at once.		1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	fYes, specify Cuba 1 □Yes 2 <b>X</b> No	in, Mexican, Puerto Specify:	o Rican, etc.)	Black, White Specify: W	hite
21215-0036	'2 hou	Completed by	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	(dan   11	   6b. Kind of Business/	Industry
121	rithin 7 ne. han "r	mple	(Specify only highest grad	College (1-4or 5+)	1	kind of work done o	during most of world)	1-	ept. of Ir	
d 2	filed within Hygiene. other than '		17. Father's Name (First, Middle, Last)		ACCO	ountant	18. Mother's Nam	ne (First, Middle, M	ederal Gov	<u>rernment</u>
Maryland	should be and Mental s marked o umatic eve	To Be	Jeremiah Meadows					e Skelton	,	
nar)	2 sho and I Is ma		19a. Informant's Name/Relationship (T)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)
e,	1 and Health em 27 ther t		Richard M. Porter/ 20a. Method of Disposition		15930	Woodlark	Dr. Bran		Maryland,	
altimore,	Pages nent of hant of hant: If ite		1 M Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	ternoval from State		sition (Name of natory or other plac Cemeter			Suitland,	·
altii	permit. P Departm Importar any injur		21. Signature of Funeral Service Licens		22	. Name and Addres	ss of FacilityHun	tt Funera	al Home	maryranu
<u> </u>	89 <b>E 8</b> 8		William all		254430	35 Old Wa	shington	Rd. Wal	dorf, MD.	
إسا	Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dene cause on each line.	eath. Do'not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	Dical	Approximate Interval Between Opset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	ACUI	C 274	Tay	70,0	VA13
		e.	Sequentially list conditions,	o	eacence offi.					
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		-4					
, 0,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
68760,	icate b physic the b	Medical		1						
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date of del	iverv
O M	death ce	Physician/	in the past 12 months? 1 ☐ Yes 2 █ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
<u>Ч</u>	hat the de d by the letached	Phy	9 ☐ Unknown  Part II. Other significant conditions con		eculting in the ur	idorlying eauto give	on in Part I	230 Did tob	acco use contribute to	the course of death?
ds,	law requires that the death ce as been signed by the attendi 2 should be detached for use	d by	ANTENIOSCUEA	DITC 6	4D100	LACULA	D 015A	1 □ Yes	•	obably 4 ☐ Unknown
Record	aw require is been si 2 should k	Completed	740161616				· · · · · · · · · · · · · · · · · · ·	24a. Was an	24b. Were au	topsy findings available
<u> </u>	The arte h	mo.						autopsy perform 1 □ Yes 2	ed? death?	completion of cause of 2 □ No
Viital	sician: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?	Jacobitali.		- I au		th (Check only one		
	Phys r this ral dir	5	1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2	ER/Outpatien		4 🗆 Nursing Ho	ome 5 Resider	nce 6 Other (Spec	cify)
<u>o</u>	nding Fath. r: After e funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	28c. Injury Work	? Yes 2 □ No	200. Describe nov	v injury occurred	
Division of	To the Hospital or Attending Physician: The Funeral State death. To the Funeral Director: After this certification of the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director is the funeral director.	ertification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	Hospital 24 hours a Funeral I stely filled	O	29a. Certifier  (Check only 2 Medical Exami	sician: To the best of my k	nowledge, death	occurred at the tin	ne, date and place	, and due to the ca	use(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	one)	ner: On the basis of exami and manner stated.	mation and/or inv					
	<b>2</b> ≥ ≥ ≥ ≥	2	29b. Signature and title of certifier			29c. License	number (/C	29	d. Date signed (Month	n, Day, Year)
ļ			30 Name and address of person who co	mpleted cause of death (It	em 23a) (Tvoe F	Print)	27 A7	127	- ZMBCR_	>, ८६८
	Be		P. WISOTSILY 1	2070 OU	LINE	CENTER	L WAC	SOLF, X	Ud. 2	9 <b>8</b> 02
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Cocks				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 14, 2008 **Physician** 2:10pM Ethel Mae Rejonis December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ravenwood Lutheran Village Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 93 Feb.Director 214-60-0950 20, 1915 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 3 15 Eckstine Court 21783 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√E No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey W. Parker Emma Crow ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary G. Rejonis 52 Geiser Way Smithsburg, Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o ooce, 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Powhatan Cemetery Powhatan Point, Ohio 20, 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JJC. **Physician** 20 Y-LAAS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Dav Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MENTIA 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy spital or Attending Physician: Ti nours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of D ath 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C the Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the time. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of cert ss of person who completed cause of death (Item 23a) (Type, Print) 22511 Jefforom BLVD SM TWONKE MD 21783 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 2, 2008 **Physician** 6:07 PM Adolphus Sam Roberts, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1<del>√</del> M 2□ F Months Days Hours 80 Sep 6, 1928 Alabama Director 421-22-8556 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, Ine "Notical Evanither must be notified at ury or other traumatic event, Ine "Notical Evanither must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director MD Anne Arundel Shadyside 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1421 Columbia Beach Road 20764 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Automobile Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Fred Roberts, Sr. Eunice Barringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other troonce. 1421 Columbia Beach Road Veronica Roberts (wife) Shadyside, MD 20764 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licenses Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreas cancel **Physician** 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Vear 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 105 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Besigne Road # 300 Annapolis, no 21401 mi 32. Registra Signature State 2008 Registrar

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	Registrar  1. Decedent's Name (First, Middle, Last)								rtificate of Death				2 Date of I	Reg. No. 4			3 Tim	e of Death	
	Physicia	an								5				Month Day Yea				: · · · · M	
	/Medic		Marian 4a. Facility Name (/	Lucil					4h City	Town or	Location of	of Death	Leca	sup	4c. County	S Dooth	TR -	> 40 tw	
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	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Madical Eventinal must be notified at	Director	10e. Street and Number												Citizen of				
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2	or II	by Fi	1 Never Marri			1 ∐Yes If Yes, G	2∙ <b>(</b> ≧ No ive	1	1 □ Yes 2	* *	Specify:				Specif		<i>Thite</i>		
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2	Hygie ther int, II		17. Father's Name		Last)						18. Mothe	er's Name	(First, Mide	lle, Maic	en Surname)				
3	ontal sed o	Be c		D. Me		ey Sı	· •					<ol> <li>Mother's Name (First, Middle, Maiden Surname)</li> <li>Grace E. Hollenshe</li> </ol>							
_	hould Me Id Me	오	19a, Informant's Na	ame/Relations	hin (Tyne	Print)		19h Maili	na Address	(Street :	and Numb	er or Rurs	d Route Nur	nher Ci	ty or Town	State 7ii	n Codel		
2	d 2 s Ith an 17 is trau		Kenneth						_				nna,Pa			, State, Zij	D Code)		
ĵ	1 an Heal tem 2		20a. Method of Dis			<u> </u>	2	Ob. Place of Dispo	osition (Nan	ne of	1	D	ate	20c.	. Location -	- City or To	own, State		
2	ages int of t: If it		17⊈ Burial 2 l	Cremation		moval from	State I		sition (Name of natory or other place)  1 Cemetery 2008				17,		aynesboro,Pa.				
	uit. Partme vrtani njury		4 ☐ Donation  21. Signature of Fu											7056		77			
3	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, i're Medical Er- once.		Jagnature of Fu	Rev /	Licensee	Day	is $M$	01414	L.L.	avis	Fune	eral	Ноте	1252 Smit	thsbu	rg,Mc	?. <u>4</u> Y	783	
	Physician /Medical Examiner		23a, Part I. Enter t	he disease, or	r complica	ations that	caused the	death. Do not en	ter the mod	e of dyin	g, such as	cardiac c	or respiratory	arrest,			Approxi	mate Between	
F			Immediate Cause		only one	cause on	each line.		bot.	v w c	tir	- h	VN6	0.	500	50	Onset a	and Death	
			disease or condition resulting in death)	on	_ a.	Due to	(or as a cor	nsequence of):	-, (					, ,					
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,																
		Jer	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, mediate	b	Due to	(or as a cor	nsequence of):											
5	uted d ansit	Examin	Cause (Disease or	erlying injury	١.		Hup	extu	~ 5. c	7									
5	exec in an ial-tr		Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):																
Ś	cate be executed physician and the burial-transit	dical			Ld.														
3	tificat g phy as th	edi			5333														
5	es that the death certificing the detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden	t pregnant	230		tcome of pr		7 Fata_ia_a						23d. Da	ate of deliv	ery		
	death e atte d for	icia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5							☐ Ectopic pregnancy ☐ Other (specify)				Month			Day Year		
)	t the by th ache	hys	9 ☐ Unknown																
-	s tha med e det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death?					of death?		
ź	quire an sig uld bu		De mentie											1 ☐ Yes 2 ☐ No 3 ☐ Probably				□Unknown	
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3	an: I	ပိ	25. Was case refer	red to medica	ı T						26 Place	of Death	1   Yes 2   No   1   Yes 2   No   1   (Check only one)						
>	/slcia s cer direct	8	examiner? 1 ☐ Yes 2 ☑	_		spital:	Innatient	2 ☐ FB/Outpatie	nt 3 🗆 DC	Othe			ne 5 ☐ Residence 6 ☐ Other (Specify)						
5 :	a Phy er thi	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at								-	28d. Describe how injury occurred							
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	ţi	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation						м										
2		iţi	3 Suicide	6 ☐ Could determ		28e. Place	e of Injury -	At home, farm, st					28f. Location	ff. Location (Street and Number or Rural Route Number,					
5	al or s afte I Dire	Certification:	4 Homicide determined building, etc. (Specify)											City or Town, State)					
	spita hours inera y fille	1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
	n 24 n 24 ne Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												se(s)				
	vithii Vomp	M	29b. Signature and	I title of certifie				*			e number			29d.	Date signe	ed (Month,	Day, Yea	(r)	
1			James muled 9060396 12/14/08																
	F		30. Name and add	ress of person	who com	npleted cau	se of death	(item 23a) (Type,	Print)	112	- 6	000	a	CF					
	1		FAY	210	M	un,	SAE	D		12	MAN	sto	um,	5	ND '	רו ב	40		
	Sta	ite	31. Date filed (Mon	nth, Day, Year)	) )/	32. 1	Registrar's S	Signature		4.3.	8		,						
	Registr	rar	DEC 2	2 200	8	Calous	As	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Donald Whitfield Shumway Dec. 3:10 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1450 North Bend Road Jarrettsville Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 91 216-03-7776 Director 3/3/1917 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location show r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or ; r must be r 1450 North Bend Road 21084 United States Funeral death 1 and 2 should be filed within 72 hours after deatheath and Mental Hygiene.
en 27 is marked other than "natural", or items; ther traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Hardware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Royer ည Channing Shumway Grace Elsie Frazier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is Donald W. Shumway Jr (Son) 1450 North Bend Rd. Jarrettsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify Entombment Loudon 12/17/08 Baltimore, MD. 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 120 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy perform 1□ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Registrar

31. Date filed (Month, Day, Year) DEC 2 2

29b. Signature and title of certifier

206 HAYS 32. Registrar's Signature

and manner stated

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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#102 BEL AIR,

29d. Date signed (Month, Day, Year)

MD 21014

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** AM DECEMBERL 0615 CHARLES W. STURGIS, SR. 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F Months Days Hours 2/19/1943 Maryland 65 Director 218-40-9744 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural" or items 23a or 28a-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 → No Director MD Harford Street 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number USA 21154 1928 Whiteford Road Completed by Funeral death v 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White If Yes. Give 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Manufacturing Repairman 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental Mary Josephine Scarborough Woodrow Wilson Sturgis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1928 Whiteford Road, Street, MD 21154 Joyce J. Sturgis/Wife Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Important; If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 12/15/2008 Darlington, MD 21. Sign ur of Funeral Service Licensee 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc., Delta, PA Part 1. Externe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final MULTI SYSTEM ORGAN FAILURE DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 YEARS STENOSIS AORTIC Sequentially list conditions, Utile to (or as a consequence rany, Isading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division of Vital Records, P.O. Box 68760, 624 the Hospital or Attending Physician: The law requires that the death certificate be executed his 32 hours and a continued to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ PERIPHERAL VACCULAR DISEASE 1 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUCTIVE PULMONARY 24a. Was an cate has page 2 s autopsy certificate 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 UNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To within 24 hours after death.

To the Funeral Director: After thi
comoletely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 PNatural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier et v. Cho Surgein D41129 DECEMBER 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2435 WEST BELVEDERE AVENUE BACTIMORE MARYLAND leter W. Cho, M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 340.71

DHMH 17 Rev 1/2001

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